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Transgenerational Transmission Of Trauma In Second Generation Latino Children And Adolescents

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TRANSGENERATIONAL TRANSMISSION OF TRAUMA IN SECOND GENERATION LATINO CHILDREN AND ADOLESCENTS

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ABSTRACT

This study explored the impact that immigration-related trauma has upon families, particularly second-generation immigrant children in the Latino-American community in the United States, and the possibility that second-generation immigrant Latinos are vulnerable to transgenerational trauma. Transgenerational trauma involves the exhibition of posttraumatic stress disorder (PTSD) symptoms in subsequent generations in families with histories of trauma exposure. Multiple linear regression was conducted to explore the existence of a correlation between PTSD and depression in second-generation Latino immigrant children and adolescents with a myriad of potentially predicting factors. Enhanced understanding of how trauma can affect the children of traumatized immigrants will add another dimension to treatment options at the disposal of mental health professional working with this population in the United States.

Keywords: immigration-related trauma, transgenerational trauma, posttraumatic stress

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CHAPTER 1: INTRODUCTION

Historical archives have long documented the exodus of civilizations from one geographic location to another. For example, historians postulate that a mass movement of people occurred 10,000-20,000 years ago from current-day Asian to North America across the Bering Strait (McGhee, 1989). Also, the Judeo-Christian tradition reverences the story of the patriarch Abraham, who migrated from lower Mesopotamia to a land then known as Canaan, to take possession of the region that would become the ancestral heritage of Jews for centuries to come (Levitt, 2003). In later years, abject poverty in Southern Europe, mainly Italy, and Eastern Europe (in the late nineteenth century and early twentieth century) resulted in large-scale emigration from countries in those regions to the United States (Moe, 2010). These are just a few of the many occurrences of societal relocation.

Historically, mass migration has not always occurred with individual's consent. The forced migration of millions of people from the continent of Africa over the course of four centuries was a consequence of the peculiar institution of slavery in the Americas (Stampp, 1956). Additionally, in 1838 Cherokees were evicted from tribal lands in the Southeastern United States and coerced into taking a journey across several states and territories on a "trail of tears" to resettle in Oklahoma (Stambaugh, Guyette, & Marschall, 2013). Such phenomena contribute to the perception in popular culture that the United States is a nation of immigrants.

Often hidden in the stories of individuals and families who have relocated in such drastic ways are pain, loss, suffering, and lasting effects, all of which can constitute the building blocks

of psychological traumatization. The effects of this separation from support networks and cultural familiarity associated with immigration, as well as challenges related to adjustment to new surroundings, constitute a critical piece of the ecological study of immigration. Immigration can be studied through a plethora of different lenses to include cultural and linguistic, economic, social adaptation, and anthropological.

In addition to studying immigration through cultural, linguistic, economic, sociological, and anthropological lenses, the impact of immigration on mental health is a critical area that should not be ignored in the conversation regarding how immigrants adjust to their host countries and the impact immigrants have upon their new environs. Although there is a body of literature supporting the existence of immigration trauma (Beckerman & Corbett, 2008; Benish-Weisman, 2009; Berger & Weiss, 2003; Perez-Foster, 2001), there is a lack of empirical research concerning the long-term mental health effects of immigration trauma upon immigrant families and subsequent generations (Slonim-Nevo, Mirsky, Rubinstein, & Nauck, 2009). More attention needs to be focused upon the study of potential, long-range traumatization of immigrant communities in the United States and upon the consequences of unresolved trauma for immigrant families as well as larger society.

Hispanics or Latinos currently comprise the largest portion of new immigrants to the United States, numbering 50.5 million, or 16% of the total population of the United States according to the 2010 Census (U.S. Census Bureau, 2011); thus, study of the effects of immigration trauma upon mental health should include this population. Migrant workers from Mexico and from other Central American countries have long populated states in the Southwest region. Various political and economic factors have stimulated growth in U.S. Hispanic population by 125% from 1990 to 2010 (U.S. Census Bureau, 1991). This quickly growing

Hispanic immigrant population faces unique mental health concerns in the United States, often fueled by xenophobia, racial profiling, language discrimination, and anti-immigrant legislation targeting undocumented, Hispanic immigrants (American Psychiatric Association Committee of Hispanic Psychiatrists, 2010). Understanding the phenomenon of immigration trauma in the United States without including the Hispanic or Latino context would constitute a drastically incomplete profile.

As the largest single minority group in the United States, the Hispanic segment of the population of the United States constitutes a substantial part of the work force and of the school-age population. Latino youth are overrepresented at all levels of the juvenile justice system, which has been tied to unresolved trauma (Weemhoff & Villarruel, 2011). Goodman and West-Olatunji (2010) have linked unresolved trauma to low academic outcomes in Latino American and African American students. Therefore, unresolved trauma, such as that caused by immigration trauma, can influence Latino youth both in conduct and academic behavior.

Unresolved trauma not only affects the academic behavior of Latino youth, but it also impacts social patterns of Latina youth. Specifically, Goodyear, Newcomb, and Locke (2002) conducted a study in which they found psychological distress and trauma were associated with Latina teens choosing to have romantic relationships with males having histories of negative relationships with women. These Latina teens also reported high rates of teenage pregnancy and intimate partner violence. Thus, the consequent risky sexual behavior provides another display of the necessity of better understanding immigrant trauma in U.S. Hispanic/Latinos.

Substance abuse is another irresponsible social behavior in Latino adolescents that has been associated with unresolved trauma. Rohsenow, Corbett, and Devine (1988) documented a study showing high incidence of childhood sexual abuse in a sample of persons in inpatient

substance abuse treatment. Substance abuse commonly co-occurs with posttraumatic stress disorder across cultures and often leads to the experience of other traumas, thus perpetuating a cycle (Kingston & Raghavan, 2009; Stewart, Pihl, Conrod, & Dongier, 1998). Unresolved immigration trauma also potentially makes immigrant families vulnerable to substance abuse and the problematic behaviors that can follow from alcohol and drug abuse.

Academic difficulty, delinquent social activity, risky sexual behavior, substance abuse have all been documented as problematic in Latino adolescents as well as linked to varying degrees to unresolved trauma. Untreated immigration trauma similarly poses a threat to the academic, occupational, and social wellbeing of Latino immigrants and their families, putting a strain on educational systems, work environments, and social service outlets which work with the segment of this population plagued by unresolved trauma. For these reasons, any focus on immigration trauma in the United States cannot ignore the experience of trauma in the Hispanic or Latino population and the subsequent socioeconomic and health problems, which emanate from unresolved trauma.

Overview

Immigration trauma is a very broad concept that can manifest itself in an individual's life as a matrix of different stressors exerting influence into a person's life at different time periods. Four stages of the process of immigration have been identified at which traumatization can occur (Desjarlais et al., 1995; Perez-Foster, 2001). These stages, which include (a) pre-migration, (b) migration, (c) immediate resettlement, and (d) long-term post-migration adjustment, will be described in greater detail in chapter two of this study.

According to the Perez-Foster (2001) model, immigrant traumatization can extend long beyond the physical relocation. Given there are potentially so many ways in which an individual

could experience trauma through the immigration experience, it is unlikely that such traumatization takes place in a vacuum without any effects or impact upon the individual's support network. Therefore, immigration trauma is better studied as a systems phenomenon rather than only in the context of the individual.

Because immigration traumatization is so broad and can affect diverse aspects of an individual's life, family members also will be exposed to the psychological distress that can result from traumatization. Evidence for vicarious traumatization in clinicians as well as in family members who offer empathic support abounds in the literature (Azoulay et al., 2005; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995). Both mental health professionals and family members can suffer vicarious traumatization when their loved ones suffer from posttraumatic stress disorder, an anxiety disorder attributed to exposure to traumatic disturbances and resulting in compromise to relational and occupational functioning, specifically evidenced by symptoms of avoidance, hyperarousal, and re-experiencing of the traumatic event (American Psychiatric Association, 2000).

While vicarious traumatization typically takes place in a time range proximate to the occurrence of the traumatizing event, a question has arisen among mental health professionals about the possibility of vicarious traumatization across different generations in families, affecting persons who were never directly affected by the traumatizing event either due to having had no exposure to the event or to having been born long after the event. To describe this phenomenon, the concept of *transgenerational trauma*, also called *intergenerational trauma,* has arisen. The concept was first conceived in the 1960s to describe the effect of Holocaust-related traumatization upon subsequent generations (Frazier, West-Olatunji, St. Juste, & Goodman, 2009; Krysinska & Lester, 2006). In the description which follows of the current research, which

is focused on the impacts of transgenerational trauma, the statement of the problem precedes explanation of the purpose of the study, research questions, need for the study, and defining terms that are utilized throughout this document.

Statement of the Problem

Various academic, interpersonal, and intrapsychic impairments are observable in U.S.-born Latino children and adolescents at levels significantly greater than in European American children and adolescents in the U.S. Although the cause of these impairments is complex, research has shown greater prevalence of traumatic experience in Latino immigrant families than in European American families. Current clinical definitions of posttraumatic stress disorder exclude the possibility that family trauma history can induce trauma symptoms in children and adolescents who did not directly experience the traumatic events. In the case of Latino immigrant families, family trauma history can be quite extensive and potentially affects the whole family system. This study aims to strengthen the argument for the existence of a correlation between immigrant family trauma history, particularly involving mothers, and the display of trauma-like symptoms in their U.S.-born children.

Exploring this relationship is critical to mitigating the impairments disproportionately experienced by second-generation Latino immigrant children and adolescents so as to afford them a clearer path to greater academic achievement, economic success, and relationship satisfaction. Multiple regression analysis is employed to test whether the presence of maternal posttraumatic stress disorder and depression can predict trauma symptoms and depression in second-generation immigrant Latino children and adolescents. Various demographic information and select psychological constructs will be tested in the regression model to explore the

possibility that they significantly contribute to the model for prediction of trauma and depression in U.S.-born Latino youth.

Purpose of the Study

Various qualitative studies and theory papers have been written to explore the experience of transgenerational trauma, mostly in Holocaust-survivor families (Lev-Wiesel, 2007; Rowland-Klein & Dunlop, 1998; Wiseman, Metzl, & Barber, 2006) but also in other populations, such as survivors of terrorist violence (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009), survivors of child sexual abuse (Frazier, West-Olatunji, St. Juste, & Goodman, 2009), those who have endured natural disaster (Goodman & West-Olatunji, 2008), and war veterans (Monson, Taft, & Fredman, 2009; Pearrow & Cosgrove, 2009). More empirical research is needed to substantiate the experiences of transgenerational trauma, which are well described in qualitative research. Quantitative study of transgenerational trauma may provide a more detailed picture of how transgenerational trauma is experienced and transmitted, but also may offer a profile of those who demonstrate resilience to transgenerational trauma when exposed to traumatizing factors.

Insights about transgenerational trauma transmission may provide mental health professionals with an expanded view of trauma diagnosis beyond the current clinical definition of PTSD. This expanded view could offer psychologically distressed young people a host of evidence-based treatment modalities that have not been available previously. Data generated about resilience can be used to design individual interventions for parents as well as group counseling and psychoeducational sessions, which inform parents of the importance of treating their own trauma for the sake of their own psychological wellbeing as well as the wellbeing of their offspring.

This study explores the phenomenon of transgenerational trauma in second generation Latino immigrant children and adolescents in the U.S. as a result of traumatization of their mothers. The study is predicated upon psychological distress in one individual igniting psychological distress in another person, such as the experience of vicarious traumatization (Pearlman & Mac Ian, 1995). This research is an extension of studies of transgenerational trauma already conducted using other populations, such as Holocaust survivor families, combat veteran families, and families victimized by terrorist violence. The primary purpose of this study is to determine if there is a significant correlation between immigrant trauma in Latina mothers and traumatization in their U.S.-born children.

Hypotheses

Hypothesis One: Are levels of PTSD symptoms in U.S.-born Latino immigrant children and adolescents predictable based on the factors of maternal PTSD symptom level, maternal depression level, meaning in life, attachment measure, number of years since initial immigration of mother, total number of children of the mother, age of the child, and gender of the child?

Hypothesis Two: Are levels of depression symptoms in U.S.-born Latino immigrant children and adolescents predictable based on the factors of maternal PTSD symptom level, maternal depression level, meaning in life, attachment measure, number of years since initial immigration of mother, total number of children of the mother, age of the child, and gender of the child?

Need for the Study

Foreign-born Latinos in the United States are less likely to take advantage of health services, including mental health resources (Kandula, Kersey, & Lurie, 2004). There is evidence that this disparity in utilization of mental health resources may be driven by language barriers, financial challenges, lack of knowledge about available services, fear due to undocumented

status, cultural stigmatization of mental health treatment, or beliefs that other resources, such as clergy, would be more helpful (Bridges, De Arellano, & Rheingold, 2010). U.S.-born Latinos utilize mental health services at a lesser rate than African Americans or European Americans (Alegria et al., 2002).

The need for understanding the root of psychological traumatization in U.S.-born Latino children and youth is critical for both community mental health personnel as well as for school-based counselors, psychologists, and social workers in devising treatment approaches. Effective parenting interventions can be designed to promote prevention of transgenerational trauma if predictors can be identified which make families susceptible to this phenomenon. High rates of depression, suicide, anxiety, academic failure, teen pregnancy, substance abuse, intimate partner violence, participation in community violence, and other mental health and interpersonal predicaments have been measured in Latino youth, particularly U.S.-born Latino youth. Occupational and academic challenges in Latino youth often lead to a lower likelihood of completion of college, lower socioeconomic standing, and the acquisition of fewer resources to empower the next generation. Understanding the mechanism by which trauma is transmitted across generations and enacting adequate interventions to mitigate effects may preclude the possibility of trauma passing from the second generation immigrant Latinos to the third generation, thus rupturing the cycle.

Definition of Terms

Definition and clarification of the usage of the following terms in the study is given below:

Hispanic refers to people or culture associated with the Spanish language and heritage tied to the country of Spain. As former Spanish colonies, many countries in Central America, the

Caribbean, and South America are associated with Hispanic culture, and their inhabitants of Spanish ancestry are known as Hispanic.

Latino refers to people or culture of Latin America, which comprises Mexico and Central America, the Caribbean, and South America. Latino encompasses a broader category than the term Hispanic. Latino includes Brazilian people, who are not typically native Spanish speakers because of Brazil's past colonial history with Portugal. The broader term Latino is often preferred and used in the United States to refer to Hispanic immigrants or people of Hispanic descent; however, the term Latino can also include non-Hispanic persons (Comas-Diaz, 2001). For this study, the use of the term Latino will apply to Hispanic immigrants or their descendants living in the United States.

Posttraumatic Stress Disorder, often abbreviated as PTSD, is an anxiety disorder involving history of exposure to a traumatic event. Specific stipulations and symptoms must be met from each of the following four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. According to the *Diagnostic and Statistical Manual for Mental Disorders*, to meet criteria for a diagnosis of PTSD symptoms must not be attributable to a substance or co-occurring medical condition (American Psychiatric Association, 2000).

Vicarious traumatization is defined as the transformation that takes place in the therapist from treatment of traumatization, producing deleterious effects in the clinician. Vicarious traumatization can alter the way the therapist views self, others, and the world. This phenomenon usually results from an accumulation of therapeutic experiences with trauma clients without intentional measures undertaken to mitigate the effect of trauma therapy upon the clinician

(Pearlman & Mac Ian, 1995). The communication of the effect of trauma can also take place between significant, intimately related persons (Krysinska & Lester, 2006).

Transgenerational trauma, also known as intergenerational trauma in the literature, is defined by Goodman and West-Olatunji (2008) as trauma passed down from one generation to the next without direct experience of traumatic stimulus by the affected person. The trauma is transmitted from a parent who did directly experience the trauma. There are no provisions for transgenerational trauma included in the criteria for PTSD in the DSM-IV-TR (American Psychiatric Association [APA], 2000).

Summary

The application of transgenerational transmission of trauma in the context of immigration trauma is rooted in the phenomenon of vicarious traumatization within families and in the experience of immigration as potentially traumatic at various stages of the immigration process. Study of transgenerational trauma in the quickly growing Latino population in the United States, steadily fueled by increasing arrivals of new immigrants from Mexico and Latin America, is very pertinent due to mental health needs easily observable in Latino youth, immigrant and U.S.-born. The subsequent literature review will explore possible relay of the effects of traumatization within Latino immigrant families and the factors that may mitigate or exacerbate this phenomenon.

CHAPTER 2: LITERATURE REVIEW

Psychology of Immigration

The phenomenon of immigration is often studied on the meso and macro scales, with attention given to the anthropological, sociological, economic, and public policy aspects of relocation from one country to another (Sullivan & Rehm, 2005; Oishi, 2002). However, physical relocation from a native country to a new geographic and cultural setting also carries with it *psychological* implications for those whose lives are so uprooted. Some of the issues related to a psychology of immigration include how people adjust to new stresses, how they redefine their identity in the new setting, and how they cope with the loss of all they left behind in their countries of origin (Berry, 2001; Berry, 1997).

The vast majority of immigrants face some type of stress in the process of *acculturation*, defined as reconciling the culture from which they originated with the culture of the new country (Garrett & Pichette, 2000). For some immigrants, acculturative stress is so extreme that it overwhelms their intrapersonal coping mechanisms, resulting in traumatization (Perez-Foster, 2001). First, acculturative stress as it relates to immigration is described below, followed by discussion of immigrant trauma.

Acculturative Stress

According to cross-cultural psychologist John Berry (1997), acculturation is a necessary adjustment process experienced by persons leaving behind their cultures of origin to relocate in a different cultural environment. Several factors determine how individuals will acculturate to their

new environments including age at the time of introduction to the new environment, gender, level of education, socioeconomic status before and after the transition, reasons for migrating, amount of cultural difference between the culture of origin and the new culture, length of time in the new country, and experience of prejudice and discrimination (Berry, 1997; Berry, Phinney, Sam, & Vedder, 2006; Suarez-Orozco, 1997). Studies that describe how these factors influence individuals' adaptation to new environments are detailed in the following paragraphs.

In a meta-analysis of several studies conducted regarding acculturation in a variety of cultural groups, Berry, Kim, Mende, and Mok (1987) concluded across cultures that women tend to endure more challenges with acculturation than men and that higher levels of education tend to correlate with less difficulty with acculturation. Smart and Smart (1995) proposed that the experience of acculturation is a stage-wise process, unfolding according to the length of time in the new country, with oscillation between initial relief, to regret, to eventual acceptance. Similar to the stages of grief posited by Kubler-Ross (1969), acculturation involves moving through a sequence of different psychological responses as new challenges and new realizations confront the person adjusting to new culture. With so many factors influencing acculturation of immigrants, acculturation is a complex process that can proceed relatively smoothly or with considerable stress depending upon the combination of factors for an individual.

Stress is so prevalent among individuals acculturating to new environments that researchers coined a term to describe this affective pattern. This term, deemed *acculturative stress*, is defined as the tension experienced by adjusting to life in a new culture and language, separating from family and other support networks, and securing housing and employment (Hovey, 2000). Acculturative stress is a common occurrence for most immigrants although many may persevere through such stress with minimal adverse effect (Levers & Hyatt-Burkhart, 2012).

The combination of acculturation factors previously described will largely determine the severity of the experience of acculturative stress for an individual. Some individuals are able to surmount acculturative stress with the ordinary resources of support network and their own ability to realign their expectations for life with reality. On the other hand, some individuals exposed to the stressors of immigration are overwhelmed by the experience and undergo drastic disruption of their occupational and relational functioning and their psychological well-being. They are not able to self-regulate and need interventions for recovery. In these cases, the acculturation experience can be described as traumatic.

Immigrant Trauma

At the extreme of the spectrum of immigration-related mental health issues lies *immigrant trauma*. Immigrant trauma refers to harrowing, traumatic experiences that happen at any stage of the immigration process, ranging from events preceding the physical relocation to occurrences associated with post-relocation (Desjarlais et al. (1995); Perez-Foster, 2001). There are four specific stages at which immigration may be experienced as traumatic. Perez-Foster (2001) labeled these four stages as (a) premigration trauma (i.e., disturbance before the physical relocation), (b) trauma during transit (i.e., distress occurring during the physical relocation), (c) short term settlement (i.e., disturbance occurring immediately upon arrival in the host country), and (d) long term adjustment in the host country (i.e., distress taking place after the immediate adjustment phase). Specific examples of immigration trauma at each of these four stages are detailed in the paragraph below.

Premigration trauma not only includes traumatic life experiences that occur immediately before physical migration. Premigration trauma is defined as traumatic events occurring just before the physical relocation that influenced the decision to migrate (Perez-Foster, 2001). This

category of trauma also includes events that may have precipitated the need for relocation. For example political violence, domestic violence, and substantial impoverishment can at times galvanize migration (Fortuna, Porche, & Alegria, 2008; Hovey, 1999; Sladkova, 2007). For immigrants from Mexico and Central America who are entering the United States without legal documentation, the physical journey can be perilous and fraught with frightening conditions. Thus, *trauma during transit* can range from extended transport in cramped and overcrowded confinement (in the back of tractor trailers or secret compartments of vehicles), sexual assault, and kidnapping human traffickers to days spent wandering in desert-like conditions with limited food and no shelter (Ugarte, Zarate, & Farley, 2004). In addition to this, experiences of prolonged exposure to the elements, animals, and fearing for one's safety from anti-immigrant patrols, and vigilante groups all meet the stressor criteria for a traumatic event involving threat of death or serious injury to self or another and a response of intense fear, horror, or helplessness as outlined in the DSM-IV-TR (APA, 2000).

Lastly, the *short-term settlement* and *long-term adjustment* challenges of finding housing and employment in an unfamiliar environment may expose immigrants to possible violence, discrimination, and mistreatment. Given immigrants often live in impoverished communities once they settle in the United States, there is a high likelihood for exposure to community violence and other potentially traumatic events during the acculturation period (Kataoka et al., 2003). A study by Kataoka et al. of immigrant students in public schools in Los Angeles, CA, revealed that 49% of the participants had been exposed to some type of community violence or victimization in the previous year and 32% showed clinical levels of PTSD. Consequently, youth exposed to trauma can then, as a result, exhibit depression, anxiety disorders, substance abuse, or academic performance problems (Saigh, Mroueh, & Bremner, 1997; Singer, Anglin, yu Song, &

Lunghofer, 1995). Consequently, immigrants are vulnerable to trauma in terms of what happens to them before, during, and after the physical relocation and may display psychological symptoms as a result of their experiences.

Immigrant trauma involves the display of posttraumatic stress disorder (PTSD), clinical depression, and acute anxiety (Arbona et al., 2010; Cavazos-Rehg, Zayas, & Spitznagel, 2007; Levers & Hyatt-Burkhart, 2012). Desjarlais, Eisenberg, Good, and Kleinman (1995) hold the position that the entire transition process of immigration, from exiting the native country to entering and settling in the host country, is potentially traumatic. However, the DSM-IV-TR (APA, 2000) qualifies a traumatic event as:

> Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat or death or injury experienced by a family member or other close associate. (p. 463)

Latino immigrants to the United States, therefore, can be susceptible to lasting psychological effects from immigration that affect their work and academic life, family life, and general social functioning.

Although there is a growing body of literature that insists exposure to traumatic events can lead to psychopathology, there is research that contradicts this assertion. Specifically, while exploring posttraumatic resilience and posttraumatic growth Klasen et al. (2010) referred respectively to the non-display of psychopathology resulting from trauma exposure and the emergence of positive changes in the lives of trauma victims as a result of the trauma (Tedeschi & Calhoun, 2004). Differing displays of psychopathology due to immigration trauma exposure in

different samples supports the idea that a myriad of different factors are relevant in determining who will experience psychological distress after trauma exposure and who will self-regulate.

Premigration Trauma. Understanding the circumstances surrounding the decision to leave one's home country is critical in understanding premigration trauma (Perez-Foster, 2001). The effects of premigration trauma, such as grief due to loss of life of loved ones in the case of political violence or sudden and drastic decrease in finances for women who leave abusive husbands in the case of domestic violence, potentially follow the immigrant into life in the host country. Newly arrived immigrants often avoid or minimize the imminent circumstances that led them to relocate to a new country when they present themselves for mental health or social services (Perez-Foster, 2001). In some instances clinicians collude with immigrant clients in avoiding the details of traumatic premigration and migration experiences by allowing their own anxious resistances to be reinforced by clients' desires to refrain from discussing the horrors of their experiences (Perez-Foster, 1998). Clinicians have the challenge of conducting more extensive histories of immigrant clients, exploring with them the motives for relocation to the host country, so that psychologically stressing and treatment experiences can be identified and factored into overall treatment planning.

Ornelas and Perreira (2011) argue that researchers have undertaken few studies to explore how factors prior to migration and the migration experience itself influence mental health; rather, emphasis has been placed in the literature largely on post-migration stressors in explaining psychological distress in immigrant populations. Ornelas and Perreira conclude, in a study of a sample of Latino immigrants living in the U.S. for an average of eight years, that having lived in high poverty in the country of origin prior to migration was strongly associated with post-migration depression. Empirical evidence exists suggesting that besides low income, low levels

of education and low social status in the home countries of immigrants can increase risks for depressive symptoms and major depressive episodes in immigrants (Nicklett & Burgard, 2009). In addition, experiencing political violence or other traumatic events can have long-term mental health consequences for immigrants (Fortuna, Porche, & Alegria, 2008). Thus, practitioners should have a thorough understanding of the events precipitating migration in order to arrive at trauma-related diagnoses more quickly and to design interventions that target the actual sources of distress.

Other researchers have recognized the need for understanding premigration trauma. Citing a lack of data on the mental health status of immigrants in Norway and a lack of attention to premigration traumatic events as the impetus for their study, Lien, Thapa, Rove, Kumar, and Hauff (2010) conducted a study of five immigrant groups to explore links between psychological distress and premigration trauma in these groups. This was an extensive study with 3,019 adult participants from Turkey, Iran, Pakistan, Sri Lanka, and Vietnam. While the researchers found significant differences in psychological distress prevalence between the groups, they also concluded premigration torture and imprisonment, due to political reasons, were most strongly linked with psychological distress in all groups. In this sample, postmigration factors were not largely associated with psychological distress (with the exception of employment status). Given this study suggests there is a strong relationship between premigratory distress and mental health impairment among immigrants, clinicians cannot afford to focus only upon their clients' current postmigration life stressors but must give due focus to premigration stressors, accepting that immigrants with grave premigration stressors but little apparent postmigration stress can still suffer from PTSD, depression, and other psychological disorders.

Berry (1990) notes the importance of distinguishing between *immigrant* status and *refugee* status when considering psychological distress among immigrants. The difference lies in the voluntariness of the relocation. Consequently, among Hispanic/Latino immigrants, Central Americans are more likely to be refugees due to civil war, violence, and government repression. Whereas Mexican immigrants are less likely to relocate to the U.S. or elsewhere due to the same sociopolitical pressures (Hovey, 1999). Premigration trauma for refugees is treated in the literature much more extensively than premigration trauma in non-refugees (Silove, Steel, McGorry, & Mohan, 1998).

In an effort to shift the focus from refugees to non-refugee immigrants, Montgomery, Jackson, and Kelvin (2013) conducted multivariate analysis of data taken from the New Immigrant Survey, a random sampling of all adults receiving legal permanent residency status in the U.S. in 2003, including refugees. Study of this sample of 8,573 adults who reported experience of premigration harm due to race, gender, or religion suggested non-political premigration harm was a predictor of general depression of borderline statistical significance (odds ratio of 1.33, 95% confidence interval 0.98-1.80, $p = .0068$) and a significant predictor of major depression with dysphoria (odds ratio of 2.24, 95% confidence interval 1.48-3.38, $p = .0001$) in the general immigrant population and not just among refugees. This suggests that premigration trauma can cause considerable psychological distress in voluntary immigrants just as it does in refugees and asylum-seekers who migrate involuntarily.

For adolescents who leave their home countries involuntarily because of the decision of a parent or caregiver, lack of control in the decision-making process is also a notable premigration stressor (Potochnick & Pereira, 2010). The adolescents may not have experienced the premigration stressors directly, as in the case of political violence, but are affected by the

parental response to the premigration stressors. This suggests that trauma can affect adolescents indirectly through the manner in which significant persons in their lives react to the traumatic event. Thus, premigration trauma includes drastic relational changes and separation as well as externally traumatic events, such as political violence, extreme poverty, and domestic violence. In summary, a diverse range of life occurrences can contribute to premigration traumatization for both voluntary and involuntary immigrants at all age/developmental levels, motivating the physical migration and influencing mental health long after the physical relocation has been completed.

In-transit Migration Trauma. The physical act of migration contains within it the potential for occasioning experiences that are very taxing on the body and on the psyche. Outside of those who, with full documentation and adequate financial resources, travel to their host country by plane, ship, or suitable land transportation, many immigrants face a perilous transition from their home countries (Sladkova, 2007). Those who journey by foot from Mexico and Central America to the United States may endure the treacherous exposure to inclement weather, hunger, harassment by strangers, and other hardships (Cornelius, 2006; Sladkova, 2007). At the U.S.-Mexico border, a growing number of self-appointed, citizen anti-immigrant groups and vigilante groups have begun patrolling the border and even shooting at people whom they believe to be crossing illegally (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008; Paget-Clarke, 1997). In 2001 such groups were responsible for the deaths of 491 undocumented immigrants trying to cross the border, averaging more than one death per day that year (Abraido-Lanza, Armbrister, White, & Lanza, 2006). Therefore, the physical border crossing for Latino immigrants without documents journeying from Mexico and Central America is clearly physically traumatic, leaving lasting effects upon those who survive the journey.

Women are particularly vulnerable in this situation, and when travelling unaccompanied by family members or trusted friends, they may be subjected to extended periods of sexual assault or forced labor by travel assistants known as "coyotes," who extort them in exchange for assistance across the border (Romero, 2011). Those traveling across the open waters of the Caribbean Sea, often in substandard vessels, from Cuba or Haiti potentially find themselves stranded and drifting for days at sea until rescued, during which time they may witness the drowning or dehydration of loved ones (Eaton & Garrison, 1992). Modern day human trafficking has created a pipeline of workers, often from Asia, who are smuggled into the U.S. illegally and unwillingly or who come willingly with false promises and false impressions of opportunities they will have. They may be transported in very inhumane conditions (Schauer & Wheaton, 2006).

As previously mentioned, the physical act of migration can be significantly more dangerous and perilous for women than for men. Systematic, militarized rape and sexual assault is a grossly misguided phenomenon that has taken place in hostile and warring regions throughout the world as a way for those in authority to assert control. While reports do exist of men being sexually assault immediately before or during border crossings, the vast majority of victims are women (Falcon, 2001).

Enloe (2000) categorizes the ways in which this takes place in terms of *recreational rape*, which happens as a result of male soldiers not having access to militarized prostitution or other sexual outlets, *national security rape,* which is characterized as a means to bolster a nervous state, and *systematic mass rape*, which is used as an instrument of warfare. Falcon (2001) depicts the sexual assault of immigrant women that has taken place along borders, particularly the U.S.-Mexico border, as acts of *national security rape* and *systematic rape*. Martinez (1998) reports

qualitative data indicating Latina women planning to cross the border often begin using birth control pills in anticipation of possible sexual assault. The association of drug smuggling with immigration and the volatile politicization of immigration reform and border control has generated the perception of invasion and resulted in the creation of a *racialized enemy* (Falcon, 2001), easily identified and categorized by Hispanic/Latino ethnicity. Falcon further proposes that the systematic practice of sexual assault on women crossing the U.S.-Mexico border from the South as been launched in response to this perceived invasion, a systematic trauma for women during migration.

In her research with Mexican immigrants from rural communities, Goldring (2001) asserts that women are willing to undergo the risks of migration, reasoning they would have an easier time finding wage-earning work outside the home, would have access to time-saving technology, would be able to exercise a greater sense of independence from men, and would be able to provide their children with better educational and employment opportunities in the United States. Such violence against women often results in visible effects that are noticeable to others, but also in existence are longer-lasting, invisible effects, such as depression and posttraumatic stress disorder (Kuoch, Miller, & Scully, 1992; Lykes, Brabeck, Ferns, & Radan, 1993). This suggests women willingly place themselves at risk for the sake of securing a better life for themselves and for their children but downplay the long-term effects of psychological distress than can result from in-transit migration trauma.

Given the importance that women give to the change in lifestyle available to them and their families through immigration to the United States (Goldring, 2001), a large number of Latina immigrant women willingly incur the risks associated with immigration to the United States. Dumont (1994) and Lykes et al. (1993) hold that the psychological effects of abuse

against women affect their families as well as the victimized individual. Therefore, the children of mothers who incur personal traumas in the immigration process are potentially affected by the psychological effects of the mothers' traumatic experiences.

Resettlement Trauma. As previously mentioned, *resettlement trauma* refers to the traumatic experiences that befall immigrants immediately upon their arrival into a new country (Perez-Foster, 2001). The nature of these experiences will vary with the sociopolitical situation of the host country, the socioeconomic position of the immigrant, and the connection the new immigrant has with family and social support. Some of the immediate challenges new immigrants faced, such as threat of deportation and changing gender roles, are described in the proceeding paragraphs.

When immigrants migrate to countries with strict legal parameters regarding border crossing and documentation, those without proper documentation must remain inconspicuous to law enforcement and other immigration authorities. Families and individuals learn very quickly that their new living situations are very tenuous in that the threat of deportation makes it necessary that they move immediately when immigration authorities are near. This can create a sense of instability that can wear on both adults and children (Zuniga, 2002) and can result in greater psychological distress than is seen in those who immigrant legally (Cavazos-Rehg et al., 2007). So undocumented immigrants are at an even greater risk of experiencing psychological distress due to their need to evade immigration authorities so that they may remain in the host country.

The Pew Hispanic Center (2009) reported in 2009 that approximately twenty percent of the U.S. Latino population consisted of undocumented immigrants. With growing efforts to enact federal and state-level legislation to curtail undocumented immigration, particularly of Latinos,

Brabeck and Xu (2010) assert that an "oppressive" atmosphere has arisen, which has increased acculturative stress and immigration trauma in those without documentation. Anxiety about legal involvement and deportation as well as lack of awareness about services has caused many not to seek mental health, medical, or social services that could ameliorate this stress and trauma (Arbona et al., 2010; Levers & Hyatt-Burkhart, 2012). In summary, heightened aggression in campaigns against undocumented immigration potentially heightens psychological distress in undocumented immigrants as well as apprehension about accessing services to treat that distress.

For immigrants to the United States coming from countries with male-dominated gender roles, there is an immediate observation of different gender dynamics in the U.S., which can cause serious tension. During the resettlement and acculturation periods of immigration, immigrants in the United States are often at a higher risk of exposure to intimate partner violence, or domestic violence, which can be a highly traumatic experience depending upon frequency, severity, and the history of the victim (Menjivar & Salcido**,** 2002). In a study of South Asian immigrant women residing in the U.S., Raj and Silverman (2003) indicated that immigrant-related factors might be predictive of more severe intimate partner violence. Social isolation, in particular, was found to increase the likelihood of the occurrence of severe intimate partner violence.

For example, women with no members of their family of origin in the U.S. were three times more likely to experience physical abuse from their partner than those with family in the United States (Raj & Silverman, 2003). Nigerian women who immigrated to Canada also describe domestic abuse experiences that are tied into cultural and socio-environmental factors (Nwosu, 2006). Nigerian culture is male-dominated and promotes the man having control over family affairs, regardless of socioeconomic status. These women report that, because the

motivation for migration is largely about financial advancement, they are typically expected to work outside the home while also being burdened with the majority of domestic, household responsibilities. The conflict that can emerge from not being able to meet these expectations to the man's satisfaction can lead to intimate partner violence.

The National Violence Against Women Survey, which was conducted from November 1995 to May 1996 and included both women and men, reported a 23.4% lifetime prevalence rate of intimate partner violence exposure for Latinos (Tjaden & Thomas, 2000). A random telephone survey conducted from January through May 2003 of more than 12,000 adult participants across the U.S. resulted in a report of 50.6% lifetime prevalence rate of intimate partner violence exposure for Latinos (Ingram, 2007). For Latino immigrants, Ingram reports that rates of intimate partner violence increase the longer Latino immigrants are in the United States, with cultural conflicts often becoming stronger as women are increasingly more exposed to different types of gender relations. These studies confirm that incidence rates of trauma due to intimate partner violence are high in Latino immigrants and the rates increase with increased time since physical migration, suggesting domestic violence is a common experience in both the resettlement trauma period as well as in the long-term, acculturation trauma period.

Acculturation Trauma. Long-term issues that exist for immigrants in the process of acculturation include the dynamic of discrimination and xenophobia, inadequate housing and under-employment, and the struggle to build a social support network comparable to what they knew in their native countries (Perez-Foster, 2001). Experiencing repeated prejudice, struggling with poverty, or suffering from social isolation can all be traumatic. Many immigrants have to contend with not just one, but all of these socio-environmental issues at once (Chung, Bemak, Ortiz, & Sandoval- Perez, 2008). These long-term issues would arguably impact family systems.

Long-term adjustment for many immigrants includes learning to navigate through environments of prejudice and discrimination. *Racism* is a socially constructed group categorization usually based on visible phenotypical characteristics, like skin color. Immigrants who are White typically enjoy the privileges and advantages of White individuals in the United States (Yakushko, 2009).

In the United States, immigrants with less of a European appearance or with more indigenous features may experience racism because of their outward differences. *Xenophobia* is distinct from racism and targets those seen as foreigners in a community, regardless of phenotypical differences (Boehnke, Hagan, & Hefler, 1998). *Racism* is typically rooted in a spirit of superiority of one race over others whereas *xenophobia* is typically rooted in a spirit of ethnocentrism, the superiority of one nation over others (Yakushko, 2009). Different historical phenomenon usually feed racism and xenophobia. Racism is driven by histories of colonialism, slavery, and segregation whereas xenophobia is connected to times of economic downturn and political volatility that spark mass migrations of people to new countries seeking stability, along with the accompanying perceived threat natives feel from the immigrant guests.

For immigrants, the subjective and objective experience of racism and xenophobia affect mental health and overall well-being. In a study of 1,016 Arab Americans living in Michigan after the September 11, 2001, terrorist attack on the World Trade Center and the Pentagon, 25% of respondents reported either personal abuse or abuse of household members, and 15% reported personally having bad experiences related to their ethnicity (Padela & Heisler, 2010). Padela and Heisler asserted that the study participants reported lower levels of happiness and higher levels of psychological distress as a result of mistreatment due to ethnic difference, indicating a link

between ethnic discrimination and psychological disturbance of immigrants with non-European appearance.

Similar discrimination has been seen specifically in Hispanic/Latino populations in the United States. A proliferation of hate crimes against Latino immigrants accompanied the very emotionally-charged debate over immigration and the emergence of state immigration enforcement laws (Johnson & Cuevas-Ingram, 2012). The 2008 *Hate Crimes Statistics* compiled by the FBI showed that a total of 1,226 individuals were victims of hate crimes motivated by the offender's bias on the grounds of ethnicity/national origin. Approximately 64% of the victims were Latino. The number of reported hate crimes against Latinos rose by 40% from 2003 to 2007. While these statistics do not distinguish among Hispanic American citizens, documented residents, and undocumented immigrants, they highlight the possible danger existing for Latinos adjusting to life in the U.S. (Duron & Smith, 2010).

Poverty among immigrant populations in the United States affects the standard of living of families and individuals in a host of ways, ranging from healthcare access and educational opportunities, to housing conditions and exposure to community violence. Recent immigrants are actually believed to display an immigrant health advantage, particularly among Mexican-origin Latino immigrants. National studies indicate that fetal death (Guendelman & Abrams, 1994), infant mortality (Department of Health and Human Services, 2000), low birth weight (Department of Health and Human Services, 2000), and adult mortality rates (Hummer, Rogers, Nam, & LeClere, 1999) are comparable to those of non-Hispanic Whites in spite of significant differences in socioeconomic status between the two groups (Finch, Do, Frank, & Seeman, 2009). Furthermore, Escobar, Hoyos-Nervi, and Gara (2000) argued that Mexico-born immigrants have better mental health than U.S.-born Mexican Americans in spite of the

socioeconomic challenges of the foreign-born Latinos, citing the effect of family support and lower standards of success in the foreign-born as possible explanations. In summary, poverty alone does not cause foreign-born Latinos to have poorer physical or mental health than their U.S.-born counterparts; rather, other protective factors, such as family network and different life expectations, cause them to display better physical and mental health than U.S.-born Latinos.

Finch, Do, Frank, and Seeman (2009) make the distinction that rates of fetal death, infant mortality, low birth weight, and adult mortality are much lower for recent Latino immigrants when compared with the rates for non-Hispanic African Americans as well. However, this initial health advantage for immigrants weakens over acculturation time and across generations. A decline in general health often accompanies long-term acculturation for immigrants.

In a study exploring relationship between body mass index (BMI) in kindergarten children and parent's income, income was positively associated with higher BMI among Hispanic immigrant families (Balistreri & Van Hook, 2009). However, BMI had an inverse relationship to household income among children of U.S.-born Hispanic parents and non-Hispanic White parents in this study (i.e., higher family income was correlated with lower child BMI). The researchers concluded that the positive correlation between parent income and BMI in Hispanic immigrant families might be indicative of cultural attitudes they hold about how to indulge children as wealth increases. This suggests that children of more acculturated Hispanic/Latino families have a different set of life expectations than those of less acculturated Hispanic/Latino families and might experience more psychological distress than less acculturated Hispanic/Latino children and adolescents when life situations are less than ideal.

Pumariega, Rothe, and Pumariega (2005) assert that children can feel very vulnerable in the face of the situations that create immigrant trauma because they see their caretakers

overwhelmed, unable to control external situations, and unable to be fully present emotionally. Pumariega, Rothe, and Pumariega hold that the emotions and memories tied to these experiences can be re-activated later by other psychological stressors. This suggests that the effects of unresolved immigrant trauma may lie dormant in families and emerge at later times triggered by other life circumstances, with the parents who experienced the traumatic events and their children consciously or unconsciously having their psychological well-being negatively affected by immigration traumas.

The Relationship Of Immigrant Trauma with PTSD and Depression

Without asserting that all immigrants experience immigration trauma or stating that the immigration experience is inherently psychologically damaging, Levers et al. (2012) make the claim that the current legal environment involving undocumented immigrants in the U.S. could cause psychological distress, anguish, as well as trauma in a population already exposed to so many other stressors. The manifestation of this psychological distress can share many characteristics of PTSD. Beckerman and Corbett (2008) suggest that "some immigrants may experience a profound or incapacitating sense of loss, disassociation, flashbacks or nightmares about separation from the homeland or family of origin that may be consistent with the symptoms of Post Traumatic Stress Disorder (PTSD)" (p. 66). Various studies document many types of profound loss and grief experienced by immigrants, which potentially result in PTSD (e.g., Fortuna, Porche, & Alegria, 2008; Rasmussen, Rosenfeld, Reeves, & Keller, 2007; Silka, 2007). According to Fortuna et al. (2008), 11% of Latino immigrants report experience of political violence while 76% report other traumatic experiences, such as sexual or physical assault, witnessing violence, community violence, HIV infection, combat, detention, deportation,

and drug-related violence (Levers et al., 2012). Therefore, exposure to the various types of immigration trauma described above potentially leads to PTSD in Hispanic/Latino immigrants.

In addition to the existence of association between immigration trauma and PTSD, immigration trauma is also related to depression. Depression and PTSD are commonly co-morbid disorders, with Breslau, Davis, Peterson, and Schultz (2000) asserting the existence of heightened risk of major depression for persons with PTSD, but not in persons exposed to trauma not manifesting PTSD. In a study of Latina immigrants in the U.S., largely Mexican and Central American, the sample was found to show depression only in participants reporting up to three traumatic experiences, but there was an increased likelihood of participants having both depression and PTSD when more than three types of traumatic experiences were reported (Kaltman, Green, Mete, Shara, & Miranda, 2010). Lipschitz, Winegar, Hartnick, Foote, and Southwick (1999) reported similar findings in a study of inpatient adolescents, concluding for hospitalized adolescent males and females exposed to multiple types of trauma, PTSD is common and highly comorbid with depression and other diagnoses. In summary, immigration trauma is manifest in individuals as a combination of co-morbid diagnoses, largely PTSD and depression, with the balance of PTSD and depression demonstrated varying with the number and types of traumas experienced.

Psychological Distress and PTSD in Hispanic/Latino Communities

By definition, PTSD diagnosis involves recognition of certain stressor events or experiences and problematic reaction to those stressors, followed by negative effects upon lifestyle, relationships, and normal functioning of the affected person. The literature suggests each of these aspects of PTSD manifest in a unique way in different cultural groups, including Latinos (Direct, 1999). Understanding these unique manifestations can improve their

identification through the creation of culturally sensitive diagnostic tools. Proper diagnosis of PTSD in immigrants affords mental health clinicians the opportunity to design treatments based on the actual source of traumatization and can lead to better understanding of consequent behaviors and psychological symptoms in the significant persons in the lives of immigrants suffering from PTSD.

Cultural Differences in Stressors

The current study is conducted on the premise that the stressors that ignite and feed psychological distresses are mediated by cultural context. In reference to the U.S. Latino population, psychological distress is manifested in a unique way, with noticeable variations in different Latino sub-groups (Miller, 1996). According to Padilla (1989), country of origin is the most obvious factor delineating within-group differences in Latino psychological distress. In a study of a sample of 258 Central American and Mexican immigrants and 329 U.S.-born Mexican Americans and Anglo Americans, Padilla found self-reports of symptoms consistent with PTSD in 52% of Central American immigrants with histories of war and political unrest, in 49% of Central Americans who migrated for other reasons, and in 25% of Mexican immigrants. Geo-political stressors greatly influence psychological distress in Latino immigrants.

For Latino families, family cohesion is generally seen as a protective factor against external stressors (Hovey & King, 1996). Based on research with a mixed sample of Latinos from different countries, Rivera et al. (2008) maintain that for Mexicans, increased family cultural conflict leads to increased psychological distress but family cohesion does not have a significant effect on psychiatric distress. In this same study family cohesion and family cultural conflict were highly associated with psychological distress for Cubans but were not significantly associated with psychological distress for Puerto Ricans. This gives further evidence to the need

to acknowledge differences within Latino sub-cultures in the study of PTSD in Hispanic/Latino immigrants in the United States.

There is an ongoing debate in the literature about the relationship between acculturation and psychological distress. Thoman and Suris (2004) found high psychological distress in Hispanic psychiatric patients with low levels of bicultural acculturation, but lower levels of psychological distress in Hispanic psychiatric patients who showed highly assimilated acculturation. Rogler, Cortes, and Malgady (1991), in a meta-analysis they conducted about research on acculturation and mental health, found a trend in the literature suggesting recently migrated immigrants tend to experience more isolation because of physical separation from family and other support, language barriers, and cultural disconnect, all of which can cause psychological distress.

On the other hand, extended time in the host country can create distance between the immigrant and traditional cultural values of the country of origin, weaken rapport between the immigrant and family members in the country of origin, result in increased exposure to discrimination, and facilitate exposure to other stressors, such as drugs and alcohol. Thus, there are arguments for both a positive and a negative relationship between acculturation and psychological distress. Rogler, Cortes, and Malgady (1991) also argue for consideration of a curvilinear relationship between acculturation and psychological distress in immigrants, that psychological distress lessens with increased acculturation to a particular point at which the opposite effect starts to manifest. Therefore, PTSD symptomology associated with immigration trauma might vary greatly in Latino immigrants according to the length of time since their migration and their level of acculturation, thus creating a complexity in how immigration-related PTSD might affect immigrant family members.

In support of the school of thought espousing the existence of negative relationship between acculturation and psychological distress, Escobar, Hoyos-Nervi, and Gara (2000) argue acculturation or Americanization negatively affects the mental health of Mexican immigrants in the United States, with lower levels of acculturation and shorter time since relocation to the United States corresponding with lower prevalence of psychological disorders. Traditional Mexican family culture provides a protective effect, evidenced through healthier diet, less tendency to use recreational drugs, and lower divorce and separation rates (Escobar, Hoyos-Nervi, & Gara, 2000). Therefore, persons from immigrant families who were born in the United States but have family histories of immigration trauma, who are likely to have higher levels of acculturation, might have a greater vulnerability to psychological distress, particularly PTSD, than their less acculturated counterparts.

In addition to degree of acculturation as a determinant for psychological distress in immigrants, age is another factor worthy of consideration. When taking into consideration psychological distress in Latinos at different stages of life development, the prevalence and risk of depression is higher for older immigrants than older U.S.-born Mexican Americans (Gonzalez, Haan, & Hinton, 2001). In contrast, Vega et al. (1998) found higher prevalence of depression among younger U.S.-born Mexican Americans than among Mexican immigrants. In a study of Asian and Latin American college students studying at a predominantly White university in the Northeast, Wilton and Constantine (2003) found length of time spent in the U.S. correlated with reports of lower levels of psychological distress in the Latin American international college students. Therefore, the interaction between the acculturation factor and the age factor is critical in understanding vulnerability to psychological distress among Latino immigrants and U.S.-born Latinos.

The interaction between gender and the acculturation factor provides another determinant that influences how acculturation takes places and subsequently the psychological distress that can develop from acculturative stress and immigration trauma. According to Gil, Vega, and Dimas (1994), the effect of acculturation strains and family pride on self-esteem in U.S.-born Latino boys decreases with increased levels of acculturation whereas acculturation strains and family pride are positively correlated with self-esteem in Latino boys not born in the U.S. Strong identification with Latino culture has more powerful effects on self-esteem as acculturation increases among the foreign born, but the opposite is true for the U.S. born (Gil, Vega, & Dimas, 1994). Thus, understanding how to predict psychological distress and PTSD in Hispanic/Latinos is incomplete without exploring how factors such as gender, acculturation level, and even age interact with each other.

Cultural Differences in Symptoms

Across different Hispanic subgroups, psychological distress is often reported as physical symptoms. Some individuals with major depression and somatic symptoms may exhibit little sadness or depressed mood during initial assessments (Lewis-Fernandez, Das, Alfonso, Weissman, & Olfson, 2005). Lewis-Fernandez et al. also stated that Mexican American women report somatic symptoms of depression more often than White women in structured interviews, and Puerto Ricans have been found to have higher rates of somatization than even Mexican Americans and non-Latinos. Primarily Spanish-speaking Latinos exhibit less differentiation of mood and somatic symptoms of depression than English-speaking Hispanics (Guarnaccia, Angel, Worobey, 1989). Therefore, clinicians must look beyond the manifestation of depressed mood in Latino clients, especially less acculturated Hispanic/Latinos in their initial encounters with these

patients to identify psychological distress (in the form of depression) that could be linked to immigration trauma.

Latino adolescents exhibit depression symptomology in a unique fashion from other groups. When compared to other ethnic groups, Mexican American adolescents show higher rates of depression and suicidal ideation than other diverse ethnocultural groups, with female Mexican American adolescents reporting the highest rates of depression and suicidal ideation (Roberts & Chen, 1995; Roberts & Sobhan, 1992). Latina adolescent girls have a higher rate of suicide attempts reported nationally in comparison to their non-Latina counterparts (Fortuna, Perez, Canino, Sribney & Alegria; 2007). Therefore, in screening for immigration-related trauma in Latino adolescents, clinicians should be especially diligent in exploring suicidal ideation as well as suicidal attempts as evidence of depression and possibly PTSD.

Cultural Differences in Occupational/Relational/Academic Effects

Valdivia and Flores (2012) report findings from a study of Latino/s immigrants in three rural Midwestern communities indicating that strong ethnic identity, greater acculturation to Anglo culture, and perceptions of low levels of discrimination and racism within the community correlate to higher level job satisfaction. As previously established, Latino immigrants are vulnerable to low acculturation to Anglo culture, discrimination and racism, and struggles with ethnic identity. The converse of the finding of the study by Valdivia and Flores would suggest that psychological distress in Latino immigrants might lead to low levels of job satisfaction.

In a study of Latino immigrants working in the poultry industry in North Carolina, Grzywacz et al. (2007) found work-family conflict infrequent in contrast to Hispanic-Americans working in the same industry. Work-family conflict refers to the extent to which work interferes with family life or family life interferes with work. Grzywacz et al. posited possible explanations

for the infrequent reporting of work-family conflict among Latino immigrant workers by the desire for financial advancement that motivated most to migrate and the tendency to tolerate more hardship and mistreatment because of undocumented status and lower levels of acculturation. Interestingly, Latina immigrant women reported more frequent work-family conflict than their male counterparts.

In a study of Mexican-American children who were victims of child abuse, Mennen (2004) uncovered a negative correlation between PTSD measure and scores on the Verbal scale of the WISC-R. There was no correlation of PTSD measure with other scales or the Full scale, suggesting PTSD primarily affects verbal intelligence or verbal intelligence mediates PTSD. The study further showed no evidence of a relationship between PTSD measure and depression in the sample, which contradicts previous research which asserted co-occurrence of PTSD and depression (Lipschitz et al., 1999). Mennen also found a substantial correlation between PTSD measure and behavior problems, substantiating previous research findings (McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988).

In terms of the manifestation of psychological distress due to acculturation, Crockett et al. (2007) uncovered acculturative stress as causing depression more so than anxiety in a sample of Latino college students. Depression has been documented to cause grade point averages of Latino adolescents to decrease (Alva & de los Reyes, 1999). Consequently, acculturative stress and immigration trauma might negatively affect academic performance in Latino college students.

In summary, immigration traumatization, consistent with the effects of posttraumatic stress disorder, influences the academic, occupational, and relational aspects of life for Latino immigrants. Challenges related to acculturation, discrimination, and financial advancement

contribute to unique ways in which Latino immigrants experience occupational and relational stressors. Similarly, research indicates that Latino children and college students experience academic stressors that have been linked to child abuse and acculturation stress. Therefore, clinicians should consider academic, occupational, and relational impairment as possible indicators of immigration-related traumatization.

Factors Related to Differential Features of Psychological Distress

Within the context of how PTSD and depression are manifest differently in Hispanic/Latinos than in other ethnic groups, there are other demographic variables that can influence who will experience immigration traumatization. The variables of gender, marital status, length of time since immigration, documentation status, and meaning in life of the mother will be explored below.

Gender. In studies of North American women, women are at higher risk levels for PTSD than men even when sexual traumas is excluded, which is more common for women (Breslau et al., 2000; Stein, Walker, & Forde, 2000). In terms of depression, gender differences start to emerge in adolescents around age 15 and continue across the lifespan, with females having higher levels of depression than males (Hankin et al., 1998; Nolen-Hoeksema & Girgus, 1994). Rivera et al. (2008) report that women of Mexican origin experience more general psychological distress than their male counterparts. Thus, gender is a critical factor to consider in exploring immigration trauma.

Given the potential for the family system to be affected by immigration trauma, it is also important to consider how female children and adolescents react to family trauma in contrast to their male counterparts. Regarding the effect of psychological distress and trauma of women upon the family, Vogel (1994) suggests daughters of trauma survivors are more susceptible to

the transmission of parental or familial trauma than sons because female children tend to identify more with parental feelings and experiences, unconsciously becoming the carrier of traumatic experiences whose memories parents may wish to escape. Therefore, gender is an important variable in studying immigration trauma in both the parental unit as well as in the offspring.

Marital Status. According to Ross, Mirowsky, and Goldsteen (1990), marriage is positively correlated with physical health, psychological well-being, and low mortality, with the unmarried demonstrating higher levels of depression than the married. Being divorced or single is related to greater overall psychological distress than being married (Rivera et al., 2008; Kaltman, et al., 2010). In terms of PTSD symptom display and persistence, a study of women that have endured sexual assault suggests those who were not married at the time of their assault were more likely to experience persistent PTSD symptoms (Dunmore, Clark, & Ehlers, 1999).

Similarly, unmarried females report higher incidences of depression than married females, unmarried males, and married males (Ensel, 1982). Hope, Rodgers, and Power (1999) suggested that a tendency towards psychological distress could influence marital status as much as marital status might influence psychological distress level. According to Hope, Rodgers, and Power, one explanation for this trend is that those with predispositions toward depression and PTSD might marry at higher rates in an unconscious attempt to alleviate their psychological distress. Nonetheless, marital status should be considered in the investigation of immigration trauma.

Length of Time Since Immigration. Nativity and length of time in the United States are both factors influencing mental health in Latinos in the United States. According to a study by Vega et al. (1998) about the effects of long-term residence upon immigrant mental health, Mexican immigrants who have lived in the U.S. at least 13 years exhibit higher rates of all

mental health disorders, mood disorders, and substance abuse than Mexican immigrants who have lived in the U.S. fewer than 13 years. Among Latina women, women who first came to the U.S. as adults had lower levels of depression symptoms than women who spent at least part of their childhood in the U.S. (Heilemann, Lee, & Kury, 2002). Another study (Lewis-Fernandez, Das, Alfonso, Weissman, & Olfson, 2005) showed Mexican immigrants had a significantly lower rate of major depression than U.S.-born Mexican Americans. The idea that Mexican American immigrants experience a lower sense of deprivation than U.S.-born Mexican Americans and have a stronger family orientation or other cultural values might explain this lower rate. Consequently, U.S.-birth is associated with higher levels of psychological distress among Latinos, and greater length of time in the United States is associated with higher levels of psychological distress among Hispanic/Latino immigrants.

Immigrant Documentation Status. In a study of documented and undocumented Latino immigrants in two major cities in Texas, the undocumented immigrants reported higher levels of immigration-related challenges than their documented counterparts (Arbona et al., 2010). Arbona et al. found undocumented immigrants were more likely to live without their nuclear family or alone and had lower English proficiency and greater adherence to traditional gender roles and family organization. According to Cavazos-Rheg, Zayas, and Spitznagel (2007), Latino immigrants concerned about deportation also reported stress related to having to accept low-paying jobs, difficulties finding desired employment, and challenges with getting promotions or salary raises. Given there is greater acculturative stress among undocumented immigrants than among documented immigrants, documentation status should also be considered as a predictor of immigration trauma.

Meaning in Life. Meaning in life is defined as a sense of one's life having a purpose or a sense that one's life is coherent, attaching one's existence to a larger framework beyond self (Reker & Wong, 1988; Ryff & Singer, 1998). Baumeister (1991) connected meaning in life with meeting the four basic psychological needs. These needs include having a sense of purpose, value, efficacy, and self-worth. Viktor Frankl (1963) proposed in his reflections on his imprisonment in the Nazi concentration camps that people approach suffering and hardships differently when they possess a sense of purpose for their lives. Thus the level of meaning in life experienced by Latino immigrants potentially has a relationship with the amount of psychological distress they experience.

Chamberlain and Zika (1992) conducted a study with young mothers with small children as well as with elderly men and women to explore relationship of meaning in life with overall psychological well-being. These factors were measured through the Purpose in Life Scale (Crumbaugh & Maholick, 1964), the Life Regard Index (Battista & Arnold, 1973), and the Sense of Coherence Scale (Antonovsky, 1993). The researchers found data for both groups showed significant associations between meaning in life and all three scales for both sample groups, with the strongest association measured with the Purpose in Life Scale, indicating that the relationship of meaning of life with psychological well-being exists as a strong relationships at opposite ends of the developmental spectrum. Therefore, meaning in life constitutes an additional factor that might have bearing on psychological distress and immigration trauma in Latino/Hispanic immigrants.

PTSD in Hispanic/Latino Youth

Current literature addressing immigrant mental health and multicultural perspectives in mental health has explored various aspects of trauma exposure by immigrant children and

adolescents (Halcon et al., 2004; Jaycox et al., 2002; Vasquez et al., 2012). Bridges, de Arrellano, Rheingold, Danielson, & Silcott (2010) conducted a study to investigate how exposure to trauma among Hispanic youth, U.S.-born as well as native born, differs from trauma exposure experienced by U.S. youth of other ethnic groups, largely focusing on the experience of primary trauma and involving participants exposed to community violence, domestic violence, and unwanted sexual behaviors, but with no direct reference to immigration trauma. The existing literature does not give adequate attention to the possibility that secondary trauma exposure can have just as detrimental an effect on mental health for U.S.-born Hispanic youth as primary trauma exposure.

Researchers have studied the refugee experience of Guatemalans who fled to Southern Mexico through the lens of youth affected by secondary trauma. In a mixed methods study of Guatemalan refugees living in Mexico as a result of political violence, Miller (1996) found correlations between mothers' depression and depression in their daughters who were either born in refugee camps or arrived in Mexico as infants. The study did not show high levels of PTSD, but Miller did conclude that the physical and mental health of Guatemalan refugee mothers influences the mental health of their female children who had not direct exposure to political violence. Parents, grandparents, and other caretakers of these Guatemalan children pass along an oral history of the reason they fled from Guatemala to Mexico and also process their grief concerning the loss of loved ones with their children.

In refugee and immigrant families, young people grow up internalizing the content of their families' relocation and related events as well as the emotional effect that these circumstances produced in the family members during the immigration process (Ajdukovic & Ajdukovic, 1993; Mghir, Freed, Raskin, & Katon, 1995). Similarly, contemporary

Hispanic/Latinos living in the United States who have experienced their own traumas before their arrival in the United States and prior to the birth of their children may pass along an oral history of their immigration that includes storytelling about these events as part of the family legacy. Therefore, immigration traumatization among Latinos can have an impact upon the entire family system.

U.S.-born Hispanic youth considered second generation immigrants whose parents experienced immigration related trauma may exhibit a unique vulnerability to symptoms of PTSD even if they have not experienced any known direct, primary trauma. The criteria for immigration related trauma are based on standards developed by Dejarlais et al. (1996) and include pre-migration occurrences, in-transit traumas, immediate settlement traumas, and long-term adjustment traumas. Given there is no single event that causes immigration-related trauma (Perez-Foster, 2001), assessing the existence of trauma in the first generation requires casting a wide net while screening for trauma.

First generation Hispanic immigrants who have suffered domestic violence and abuse, life threatening border crossings, sexual assaults, drastic and sudden separations from family and other support networks, or severe discrimination and maltreatment upon entry into the United States are all susceptible to experiencing PTSD symptoms if protective factors and healthy stress responses are absent. Their children, although born in the U.S., may also be susceptible to suffering PTSD symptoms arising from their parents' and grandparents' traumatic immigration experiences. Unlike foreign-born Hispanic youth who can provide first-hand reports of any personal trauma during their immigration experience, youth who suffer from immigration trauma transmitted through the family may go undiagnosed by clinicians who only assess for personally experienced trauma. Therefore, the aim of this study is to provide justification for the

broadening of the criteria clinicians use in assessing trauma in Hispanic/Latino children and adolescents.

While clinicians easily may recognize symptoms of immigration trauma (i.e., PTSD and depression) with foreign born Hispanic youth, these same clinicians may overlook the symptoms of U.S.-born Hispanic children and adolescents because of the lack of trauma history. Bridges et al. (2010) highlights one of the reasons for this lack of recognition. Bridges et al. suggested that there is a marked difference in the way in which foreign-born Hispanic youth and U.S.-born Hispanic youth react to trauma. Specifically, U.S.-born Hispanic youth *externalize* psychiatric disorders by engaging in delinquent behaviors more frequently than foreign-born Hispanic youth. Conversely, Hispanic born youth tend to *internalize* distress. This behavioral pattern (i.e., internalizing issues) can lead to higher rates of depression and anxiety. Bridges et al. also cited the inadequate number of studies contrasting the difference between the ways in which foreign-born Hispanic youth versus U.S.-born Hispanic youth react to trauma. Heightened understanding of how U.S.-born Hispanic children and adolescents uniquely manifest psychological distress is critical in understanding the transmission of immigration trauma within families.

Age may be another key determinant in understanding the effects of immigration trauma on individuals within the family system. In a study of children diagnosed with depression who also had parents who were diagnosed with depression, Weissman et al. (1987) found the onset of depression to be uncommon in children before puberty. However, Weismann et al. found the mean onset age of depression in adolescents to be lower (around age 12 or 13) in the children of depressed parents than in the children of non-depressed parents (around age 16 or 17). Therefore, the age of the child might also be a significant factor in determining how families are affected by immigration trauma.

Transgenerational Trauma

Various geopolitical events that took place at the beginning of the 21st century (i.e., long-term U.S. military engagement in various parts of the world and terrorist-related violence) have generated an interest in further study of trauma. PTSD first appeared in the DSM-III in 1980, with an initial focus on the diagnosis and treatment of veterans (Scott, 1990). The diagnostic criteria of PTSD have been expanded to encompass a wider range of catastrophic experiences, such as natural disasters, terrorist attacks, and mass transportation accidents, which may cause occupational, relational, or academic impairment (APA, 2000). Drastic or sudden changes in interpersonal support systems, harsh economic and personal finance adjustments, along with discrimination and prejudice all could constitute traumatic experiences (Perez-Foster, 2001). Immigrants commonly undergo all three of these experiences before, after, and during their physical transitions. Therefore, clinical sensitivity is needed toward the experience of PTSD in immigrant populations.

Whereas the primary focus of recent research on immigrant trauma has centered on first generation immigrants who themselves relocated from one country to another, there has been a growing recognition of the impact of immigration trauma upon family systems (Suárez-Orozco, Bang, & Kim, 2011). Mental health clinicians are trained to be vigilant about over-identifying with the traumas of individuals they treat, thus becoming vulnerable to *vicarious traumatization*, or *secondary traumatization*, characterized by the transfer of the effects of trauma from the trauma victim to the clinician (Pearlman & Mac Ian, 1995). However, vulnerability to some form of vicarious traumatization is also a concern for other significant support persons and family members of trauma victims (Krysinska & Lester, 2006).

The mechanisms by which trauma can be transferred interpersonally have not been exhaustively identified. A study of the U.S. Holocaust Memorial Museum staff, McCarroll, Blank, and Hill (1995) found that sustained exposure to documents, video, and other records of trauma can cause vicarious traumatization of staff, indicating the transmission of trauma does not have to happen solely from person to person. The concept of transgenerational trauma, or intergenerational trauma, has emerged to denote the phenomenon of the effects of trauma extending from one generation to the next in the same family (Bender, 2004; Dass-Brailsford, 2007; Frazier, West-Olatunji, St. Juste, Goodman, 2009; Goodman & West-Olatunji, 2008). In the context of immigration trauma, the children and even the grandchildren of first generation immigrants may experience the psychological effects of the traumas experienced by their parents and grandparents in the process of immigration.

Holocaust Survivor Families

Attention to transgenerational trauma in the professional psychological community began in the 1960s with the study of psychological distress and interpersonal relationship tensions in Jewish Holocaust survivors and the subsequent generations of their families (Abrams, 1999; Frazier, West-Olatunji, St. Juste, Goodman, 2009). Fossion, Rejas, Servais, Pelc, and Hirsch (2003) assert that the existence of transgenerational trauma in Holocaust survivor families is controversial because of the lack of sufficient controlled studies confirming increased rates of psychopathology in survival families, yet they recognize mental health clinicians routinely factored transgenerational trauma in the treatment of Holocaust survivor families. In a meta-analysis of 32 sets of research samples, Van Ijzendoorn, Bakermans-Kranenburg, and Sagi-Schwartz (2003) found the offspring of Holocaust survivors less well-adapted than comparison groups only in clinical samples already stressed by other psychological or physical illnesses,

suggesting explanations for psychological distress in survivors beyond transgenerational transmission.

In contrast, various studies support the existence of transgenerational trauma in Holocaust survivor families. In a study of 215 Jewish North Americans, Giladi and Bell (2012) found second generation Holocaust survivors to report significantly higher levels of secondary traumatic stress than the control group which participated in the study based on exposure to other types of non-Holocaust trauma. Similarly, a non-clinical study of 285 offspring of Holocaust survivors with two survivor parents in Australia measuring subjective well-being resulted in the offspring of Holocaust survivors indicating lower general positive mood than non-Holocaust survivor offspring (Weinberg & Cummins, 2013). Although the scientific community has clearly defined transgenerational trauma and has conducted numerous studies supporting the existence of transgenerational trauma, there is still a need for further confirmatory research.

In theories of transgenerational trauma in Holocaust survivor families, researchers do not contend that all second generation Holocaust survivors suffer from the effects of Holocaust-related trauma. Rather, there are various factors, known and unknown, which make some survivors more vulnerable than others. Krysinska and Lester (2006) posited that while most children of Holocaust survivors are highly-functioning, some children of Holocaust survivors routinely exhibit problems with affectivity, self-identity, cognition, and interpersonal relations. Kellermann (2001) further concluded that risk for transgenerational traumatization in Holocaust families increases for situations in which (a) both parents were Holocaust survivors, (b) both parents experienced great suffering, (c) parents lost other children during the Holocaust, and (d) children vulnerable to trauma transmission were born in the first decade after the war. Thus,

transgenerational trauma in Holocaust survivor families is a very complex phenomenon requiring understanding of the vulnerability factors and mechanisms of transmission.

Regarding mechanisms of transmission, Lurie-Beck (2007) argued that the symptoms of trauma are transmitted from one generation to the next when parents' unresolved grief, depression, or generalized anxiety and hyper-vigilance impede their ability to achieve healthy attachment to their children and meet the children's emotional needs. The inconsistency of the parental relationship may lead children of Holocaust survivors to feel unsure of the extent to which they can trust their parents to meet their needs. Brom, Kfir, and Dasberg (2001) observed that Holocaust survivors may excessively cling to family members at times to protect them from being hurt or lost but at other times may remain detached from family members to protect themselves from being hurt in the event that some harm should come to the family members. Consequently, children of Holocaust survivors might have been fearful of their parents because they were never sure which reaction to expect.

Length of time between the end of the Holocaust experience and the birth of the children of survivors is another important factor relevant to Holocaust-related psychological distress in second generation survivors. Lurie-Beck (2007) documented that younger children of Holocaust survivors were more vulnerable to the transmission of trauma. Older children, especially those who had some experience of their parents' parenting style prior to internment in the concentration camps, had greater protection against the trauma transmission. Children born very shortly after the war ended experienced a similar vulnerability to those children who were young at the end of the war.

Porter (1981) imaged the first child born after the end of the war as a symbol of resurrection and new life for the survivor family. This first-born child would have had more

exposure to the parents' trauma symptoms due to having spent more time alone with the parents than subsequent children, allowing more time for communication of distress. Children who came later after the end of the war experienced a buffering by their older siblings. Thus, lower birth order provided a protective factor among the children of survivors concerning Holocaust-related trauma transmission.

Applications of Transgenerational Trauma Theory

Beyond the application of the concept of transgenerational trauma to Holocaust survivor families, the literature contains increasing references to studies and other works citing trauma-related intergenerational interactions. Most prevalent in the literature are studies about combat-related trauma being transmitted from veteran parents to their children (Davidson & Mellor, 2001; Dekel & Goldblatt, 2008; Rosenheck & Fontana, 1998; Scaturo & Hayman, 1992). Also common are studies and theory papers about collective transgenerational trauma in oppressed groups concerning systematic traumas spanning several generations, including Native American communities (Braveheart, 2000), Australian aboriginal communities (Menzies, 2008), as well as African Americans as descendants of slaves (Leary, 2005), all of which will be discussed below.

Combat-Related Trauma. Considerable scholarly interest has emerged around the possibility for transgenerational transmission of trauma from persons experiencing PTSD from combat duty to their children. Rosenheck and Fontana (1998) conducted studies exploring the intergenerational effects of trauma within father–son dyads of veterans, using Vietnam veterans whose fathers had their own combat experience as well as fathers who did not. Veterans whose fathers had combat exposure demonstrated more intense and pervasive psychological distress.

According to Pearrow & Cosgrove (2009), in the case of the combat veteran family, veterans with PTSD have difficulty connecting with their families, leading to dysfunction in

emotional expression and communication and eventual emotional withdrawal from the family. The emotional withdrawal often leads to re-experiencing of trauma cues or angry outbursts, which lead to emotional detachment from the veteran by the children or intense preoccupation with protecting the veteran from any event or encounter. This pattern of detachment and preoccupation might bring about emotional stress. One of the strongest predictors of transgenerational trauma in children of veterans with combat-related PTSD is the intensity and duration of trauma exposure of their veteran parents (Ancharoff, Munroe, & Fisher, 1998). The more grave the veteran parents' exposure to trauma, the more likely their children will be affected by the unresolved traumatization of the parents.

As in the case of transgenerational trauma in Holocaust survivor families, there are studies contraindicating the existence of transgenerational trauma transmission in combat-related trauma families. A study of Australian Vietnam War veterans and their children showed no evidence of any significant relationship of posttraumatic stress and self-esteem of veterans manifesting PTSD with self-esteem and stress levels of their children, thus refuting the occurrence of transgenerational trauma transmission in the study sample (Davidson & Mellor, 2001). Nonetheless, researchers have created a template for the study of transgenerational trauma in other populations from the extensive attention given to the topic of transgenerational trauma in veteran families.

Historical Trauma. A body of literature focused on historical trauma has also arisen characterizing transmission of mass, corporate traumas over several generations. Historical trauma is defined as cumulative emotional and psychological traumatization over lifespans and across generations of particular groups resulting from long-term systemic oppression and collective traumatization, such as the descendants of enslaved Africans in the

U.S. (Frazier, West-Olatunji, St. Juste, & Goodman, 2009) or Native Americans (Braveheart, 2000). Whereas transgenerational trauma can be tracked over three or four generations within a family, historical trauma can be tracked over several generations in large groups of people, with multiple families experiencing the effects (Wiechelt, Gryczynski, Johnson, & Caldwell, 2012). Both African Americans and Native Americans have endured more than 500 years of physical, emotional, social, and spiritual genocide from European and American colonialist policies.

In the case of African Americans, historical trauma includes slavery, race-based segregation, and discrimination, which have impacted access to health, education, social and economic resources (U.S. Department of Health and Human Services, 2001). Leary (2005) proposes some African Americans today are suffering from Post Traumatic Slave Syndrome (PTSS), a type of trauma connected to the systematic dehumanization of African slaves passed down through generations of their descendants. PTSS is compounded by ongoing oppression of African Americans and other cultures outside the dominant culture. Just as some individuals exposed to trauma do not demonstrate symptoms of PTSD due to various protective factors, many African Americans function without psychological distress and without occupational and relational impairment related to historical trauma. Nonetheless, PTSS is likely related to many of the social problems impacting the African American community, such as poverty, elevated high school drop-out rates, substance abuse, and domestic violence (U.S. Department of Health and Human Services, 2001).

Similar to the residual effects of slavery and segregation in the African American community, Native Americans still experience the effects of European colonization and systemic oppression by the U.S. government. The removal of ancestral lands, the isolation of Native Americans onto reservations with limited resources, and the enactment of programs that removed

Native American children from their families to be placed in orphanages for the purpose of "Americanization" are examples of the occurrences that have triggered historical trauma in Native Americans (Davis, 2001). In the case of contemporary Native American life, while many exhibit healthy lifestyles and are economically stable, a significant contingent of Native Americans struggle with historical unresolved grief that is connected to depression, suicidal thoughts, anger, anxiety, low self-esteem and difficulty in both recognizing and expressing emotions (Braveheart, 2000; Wiechelt, Gryczynski, Johnson, & Caldwell, 2012). In summary, transgenerational trauma has impacted several populations over extended periods of time, but with various factors defining how historical trauma influences not only individual psychological well-being but the communal mental health and psychological well-being of large cultural groups.

Child Sexual Abuse. History of maternal childhood sexual abuse (CSA) influences the parenting attitudes and behaviors of women who are survivors of abuse (Cohen, 1995). In a study (Barcus, 1997) conducted with men whose wives or partners were CSA survivors, spouses reported volatile mood shifts, depression, withdrawal, and anger in their wives and partners. These shifts in mood impacted the couples' children and sometimes were directed at the children. Explanations of the erratic emotions frequently could not be shared with the children. In cases such as this, children might absorb the depressive emotions of their caretakers, particularly their mothers (Goodman & Gotlib, 1999).

Although poorly supported in the literature with other empirical studies, McCloskey and Bailey (2000) postulate that children of CSA survivors are at higher risk of being sexual abuse victims than children of non-CSA parents. In a study of 179 preadolescent girls and their mothers, McCloskey and Bailey reported girls whose mothers were sexually abused as children

were 3.6 times more likely to be sexually victimized. In the case of transgenerational trauma in families of childhood sexual abuse, there exists the risk of children unconsciously imitating the emotional displays of their parents who were victims. This mirroring of the emotions of the parents may produce unexplained depression, hyperarousal, and anxiety, as well as create the risk of these children being sexually victimized themselves. The children of CSA victims who themselves are not sexually abused potentially display the psychological symptoms of their victim parents although they never directly experienced the trauma of sexual abuse, constituting another context in which transgenerational transmission of trauma may take place.

Theories of Transmission

Although there are multiple contexts in which children and adolescents endure transgenerational traumatization, these contexts converge at the level of the mechanisms through which trauma is transmitted. Various models for the transmission of transgenerational trauma have been proposed in the literature (Dekel & Goldblatt, 2008; Kellermann, 2001; Sochos & Diniz, 2012; Yehuda et al., 2005). Kellermann (2001) identified four potential theoretical approaches to understanding trauma transmission across generations. These approaches include (a) psychodynamic, (b) sociocultural, (c) family system, and (d) biological models of transmission.

Rather than claim that any one approach exhaustively explains how trauma is transmitted, Kellermann (2001) espouses a position of integration of approaches by which trauma transmission is caused by a complex of biological predisposition, individual developmental history, family influences and social situation. For the purpose of this study, the researcher has collapsed the four categories of Kellermann into the following three potential theoretical

approaches for trauma transmission: (a) biochemical, (b) narrative, and (c) attachment. The role of each theoretical approach in transgenerational trauma transmission will be discussed below.

Biochemical. Biochemical models of transgenerational trauma transmission suggest vulnerability to traumatization because of genetic, epigenetic, or other biochemical factors. This approach implies that parental memory organization that has been altered by an experience of trauma can be passed down to the children. Consequently, some persons may inherit a vulnerability to stress (Kellermann, 2001).

Matthews and Phillips (2010) outlined a growing body of research that indicates significantly higher or lower cortisol levels in children of mothers who had actually suffered from PTSD in their third trimester of pregnancy. Cortisol levels of children of women exposed to the September 11, 2001, World Trade Center attack and who subsequently developed PTSD were significantly lower than the children of non-PTSD mothers exposed to the attack (Yehuda et al., 2005). Yehuda et al. found that reduced cortisol levels in adults with PTSD were a significant factor influencing transmission of trauma effects.

The body typically releases cortisol, a steroid hormone, in response to stress to bring the body back to homeostasis. Lower than normal cortisol levels compromise the stress-response, which is a primary protective factor against PTSD, and create vulnerability to PTSD. For women who had experienced traumas before or during pregnancy and were diagnosed with PTSD, their own low cortisol levels translated to low cortisol levels in their newborn infants. This was posited as a partial explanation for the transmission of trauma from a biological standpoint, making these infants vulnerable to anxiety and stress because of a subsequent compromised stress-response.

On the other hand, high cortisol levels in expectant mothers have been correlated with high cortisol levels in their children (O'Connor et al., 2005). Sustained higher than normal cortisol levels place a person in a state of constant hyperstress from which it is difficult to relax (Scott, 2011). A longitudinal study of mothers who had experienced late pregnancy anxiety and their children from those pregnancies at 10 years of age showed a significantly higher awakening salivary cortisol secretion in the children than in the control group after controlling for other obstetric factors (O'Connor et al., 2005), which affected the stress-response. Consistent higher than normal cortisol levels are characteristic of persons who suffer from psychopathological levels of anxiety, attention deficit hyperactivity disorder, and other externalizing disorders (Van den Bergh & Marcoen, 2004).

Similarly, a study of adolescent children born to women exposed to the Chernobyl disaster of 1986 and who were pregnant after the disaster revealed significantly higher cortisol levels in these adolescent children than in the comparison group (Huizink et al, 2008). Matthews and Phillips (2010) recognized that exposure to traumatic events does not always result in PTSD due to the possible existence of protective factors, but the cortisol changes seemingly transmitted from mothers to children *in utero* have been viewed as a possible evolutionary strategy designed to protect children who would be born into hostile, threatening environments. Understanding how trauma is transmitted between generations, biologically and psychologically, is an optimal starting place for better understanding how to assess and treat transgenerational trauma.

Attachment. Within the realm of the psychodynamic approach to explaining transgenerational transmission of trauma lies attachment theory. Proponents of attachment theory hold that cognitive schemas developed from early-life, repeated experiences with caregivers influence how individuals view and behave in relationships with others (Bowlby, 1969).

Grounded in developmental psychology and evolutionary psychology, attachment theory is based upon the importance of providing a safe environment for the child through the caretaker-child relationship. Most infants have an attachment figure by 7 months of age months who serves as a secure base from which the child can test new surroundings. Later relationships with others are an extension of the first caretaker-child relationship (Bowlby, 1980).

According to the psychodynamic approach to transgenerational transmission of trauma, children unconsciously absorb unresolved grief and other negative emotions related to traumatic experience of the parent or caretaker (Goldman, 2004). Kellermann (2001) proposes that parents may project their feelings and anxieties related to a trauma onto the children and that the children may assume these feelings as if the children personally underwent the traumatic experience, known as introjection. Attachment theory focuses more on mother-child relations than on father-child relations because in most cultures, mothers perform greater levels of childrearing than fathers (Ainsworth, 1979). Schwerdtfeger and Goff (2007) specifically identified maternal trauma exposure as having a substantial effect on transgenerational trauma transmission and advocated for more extensive trauma history assessments for expectant mothers to ideally prevent the potential transmission of trauma symptoms between mother and child. Thus, the closeness of the child-caretaker relationship creates the opportunity for sharing of intense emotions stemming from trauma from caretaker to child, resulting in children showing PTSD symptoms.

Applying this same concept of attachment to adults, Bartholomew and Horowitz (1991) posited the following four adult attachment styles: (a) secure, (b) dismissing, (c) preoccupied, and (d) fearful. Relations with the primary caretaker as a child influence the style of attachment individuals exhibit as adults. Secure attachment refers to a person with a good sense of self-

worth and who is responsive to others while dismissing attachment refers to a person with a good sense of self-worth but who views others negatively. Preoccupied attachment depicts a person with a low sense of self-worth but a good opinion of others while fearful attachment refers to the individual with a low sense of self-worth and distrust of others. According to this categorization schema, attachment style is based on the individual's view of self and of others (Griffin & Bartholomew, 1994).

Several measures of adult attachment style have emerged based on the belief that attachment style is stable across the life span (Ainsworth, 1982) and the theory that there is a relationship between attachment style and psychological dysfunction in adults. In a study of 66 participants, Muller, Sicoli, and Lemieux (2000) found a strong correlation between the attachment construct sense of self-worth and PTSD. Thus, the focus on attachment is a potential lens for better understanding trauma.

Although Bowlby (1969) presented his attachment theory as universal across cultures, there is a growing interest in the role of culture in attachment theory, which challenges the current paucity of attachment studies with non-Western samples including validation of attachment measures among diverse cultures (Wang and Mallinckrodt, 2006). Using data collected from Western Europe, the United States, Israel, Japan and China, van IJzendoorn and Kroonenberg (1988) found that both *intra*cultural differences in attachment style measures and intercultural differences in attachment style exist, with intracultural differences being 1.5 times greater than *inter*cultural differences. Consequently, different ethnic groups, such as Hispanics/Latinos, may attach to significant persons in their lives in a characteristic way.

Concerning the effect of trauma on attachment, Bar-On et al. (1998) suggested mothers affected by trauma may provide their infants with inconsistent care, possibly igniting

development of insecure attachment. Main and Hess (1990) similarly argued poor coping skills in the mother may result in inconsistent parenting and the child seeing the mother as a frightening figure. Consequently, the inability of mothers to create secure bonds with their children because of their own psychopathology potentially leads to children maturing unaccustomed to having secure and reliable relations with the significant persons in their lives and developing a general attitude of insecurity.

Furthermore, Sagi-Schwartz et al. (2003), in a study of Holocaust survivors and their female children, concluded that not only might trauma be transmitted from generation to generation but that attachment style may be largely communicated between generations. In the study fewer secure attachment representations were measured in the Holocaust survivors than in the non-Holocaust survivor comparison group. Also, there was significant interaction between attachment security and birth generation, suggesting transmission of attachment security from the first-generation subjects to their daughters. This significant interaction was present in the Holocaust group as well as in the comparison group, implying attachment style was passed from generation to generation in both groups. Thus, intergenerational transmission of trauma may be partially explained by intergenerational transmission of attachment styles.

Given the connection between transmission of trauma and continuation of attachment styles between generations, knowing the attachment style of individuals potentially generates insights into how they will react to traumatic events. In a study of 275 Palestinian former political prisoners, Salo, Qouta, and Punamaki (2005) concluded that secure attachment as opposed to insecure attachment in torture-trauma victims mitigated the onset of negative emotions. Thus, in that study attachment style appeared to have had a direct impact on their

ability to cope with trauma, with insecure-preoccupied attachment being a significant predictor of PTSD.

Building upon previous research exploring the relationship between attachment style and psychological distress and sociocultural adaptation in immigrants, Sochos and Diniz (2012) lay out the results of a study they conducted with Brazilian immigrants living in the UK concerning which attachment styles moderate the psychological and sociocultural effects of immigration. The researchers concluded that secure attachment generally mitigates the effects of psychological distress and sociocultural adaptation challenges in the sample. Dismissing attachment style was also shown to have some protective impact on psychological distress in immigrants.

According to Sochos and Diniz (2012), preoccupied and fearful attachment styles, on the other hand, corresponded with higher levels of psychological distress and sociocultural adaption stressors. Preoccupied and fearful attachment individuals are less likely to have strong support systems and are more likely to isolate themselves for lack of trust of others different from themselves, resulting in high distress levels. Therefore, attachment styles influence how individuals seek support during moments of psychological distress, including trauma, with individuals demonstrating preoccupied and fearful attachment styles being less likely to have supporting relationships that offer a barrier to PTSD, depression, and other psychopathologies that result from traumatic exposure.

Future research might involve qualitative, phenomenological work to explore the in-depth experiences of immigrants displaying the four attachment styles. There is also a need for further research with other culturally diverse groups. In summary, attachment style provides a possible predictor of who will be vulnerable to the transgenerational transmission of trauma by

way of the likelihood that children will mirror similar attachment styles to the attachment styles of their mothers.

Narrative. The family systems approach identified by Kellermann (2001) is primarily based on enmeshment and lack of individuation in the family, which largely is manifest in the form of non-verbal, vague, and guilt-laden communication as well as silence (Danieli, 1998; Klein-Parker, 1988). Children of parents with PTSD may become enmeshed in the emotional instability of their parents and may be hindered in forming independent affectivity. In this sense, attachment and bonding between children and the family unit plays a role in the emotional and cognitive worldview of children. Weingarten (2004) also proposes that selective sharing of details about past family traumas potentially leads to children becoming witnesses to the traumatic event and in some cases incurring traumatization themselves, thus offering narrative theory explanation for how trauma can be transmitted between generations.

Small children are particularly vulnerable to the internalization of emotions of caretakers who have experienced trauma and heightened anxiety (Appleyard & Osofsky, 2003). Schechter et al. (2007) conducted a qualitative study of 24 mothers and 25 children ages 4-7 years old in which the mothers had been exposed to family violence and maltreatment and subsequently suffered from PTSD. It was revealed that these children conveyed high levels of danger, helplessness and hostile aggression. During the mothers' narration of their experiences, their children demonstrated heightened distress and avoidance, suggesting an inability on the part of the mothers to shield these children from their own affect and arousal dysregulation during the retelling of the trauma story. Therefore, children may mirror the emotional experience of their mothers as they recount traumatic events or as other threatening events are discussed, causing them to show some PTSD symptomology.

Ancharoff, Munroe, and Fisher (1998) have identified the following four potential mechanisms to explain how trauma is transmitted across generations (a) silent avoidance, (b) overdisclosure, (c) identification, and (d) reenactment. Silent avoidance refers to the child's circumvention of stimuli possibly disturbing to the parent, resulting in increased anxiety as the child chooses not to seek help from the parent in an effort to protect the parent. Overdisclosure is unfiltered sharing of the details of trauma, resulting in the child being horrified. Identification refers to identification with and mirroring of the symptoms of the parents in order to connect with the parent. Lastly, reenactment occurs when the child is involved in some level of reenactment of the trauma. Silent avoidance and overdisclosure are critical pieces in narrative explanations of trauma transmission (Dekel & Goldblatt, 2008; Frankish & Bradbury, 2012). From a narrative theory perspective, failure to share information in an age-appropriate fashion as well as excessive sharing of trauma-related information can both be detrimental to the psychological well-being of children and adolescents in a family.

Frankish & Bradbury (2012) identified a trend of selective sharing in what mothers and grandmothers chose to discuss with future generations concerning apartheid violence in South Africa. Silence and what families choose not to discuss is just as influential as what they choose to discuss in the transmission of trauma. The women in this study preferred to paint images of a time in their lives before apartheid violence climaxed to present to their families. Because much of the violence that occurred was known to the community, children and grandchildren were aware of what happened, but they rarely had an opportunity to process these stories within the family. Mothers and grandmothers articulated wanting to protect their children from the urge to become violent by remaining silent about what had happened to the children's fathers, grandfathers, and uncles. Given this orchestrated silence, children were left to try to make sense

of the family trauma history on their own and internalized anger, resentment, and fear without being able to process it in the family, thus facilitating transmission of trauma through impartial storytelling.

Dekel and Goldblatt (2008) cite family communication patterns as significant modes of transmission of transgenerational trauma. In the case of families with fathers who are war veterans, sensitive conversations may be avoided to prevent aggravating the father's distress associated with the trauma. Withholding knowledge about traumatic combat, experiences can lead to children and young people providing the missing details themselves, often constructing a narrative more harsh than the reality.

Similarly, excessive disclosure risks placing children and young people in a position to process information for which they are not developmentally prepared. Grandmothers and mothers of families that endured apartheid-related violence in South Africa expressed feelings that talking about certain family traumas was redundant because the traumatic events were very public and the generation born after the elimination of apartheid learned about the violence and family traumas in the community (Frankish and Bradbury, 2012). This orchestrated silence led to the creation of a number of disjointed and inaccurate narratives about family traumas. It is the stories that families choose not to share and the emotional energy expended upon safeguarding the silence that surrounds certain narratives that perpetuates traumatization across generations. Thus, Hispanic/Latino immigrant families that avoid sharing with their U.S.-born children their immigration histories, including traumatic events, may convey the negative psychological effects of the trauma inadvertently by their own silence.

Conclusion

The implications of the possibility for transgenerational trauma in U.S.-born Hispanic youth creates a responsibility among mental health clinicians to explore an additional layer of the mental health of clients who fit this demographic. Goodman and West-Olatunji (2008) have identified two helpful instruments in assessment of transgenerational trauma, the Multidimensional Trauma Recovery and Resiliency Scale and the color-coded timeline trauma genogram. Although the DSM-IV-TR does not technically and explicitly recognize transgenerational trauma (APA, 2000; Goodman and West-Olatunji, 2008), identification of trauma symptoms as a result of the trauma experienced by a client's previous generations does give clinicians obvious considerations for treatment. Cultural sensitivity and linguistic concerns are challenges that must be addressed in working with this population for effective assessment. Further research is needed to explore how trauma is transmitted in Hispanic culture and what protective measures can be taken to prevent trauma transmission as well as to treat already existing transgenerational trauma in a culturally sensitive manner.

CHAPTER 3: METHODOLOGY

Methodology

This study aims to provide quantitative support of the existence of transmission of immigration trauma between Latina immigrant women and their U.S.-born children, known as transgenerational trauma. By measuring PTSD and depression in Latina immigrant mothers, both of which are potential consequences of immigrant traumatization, and PTSD and depression in second generation Latino immigrant children, analysis was conducted to determine whether symptoms in the mother groups are related to symptoms in the offspring group. Other factors also were tested to determine whether they play a statistically significant role in predicting significant correlation between traumatization in mothers and traumatization in their children.

Participants

Participants in the study consisted of dyads of Latina immigrant women who have migrated from a Latin American country to the United States and who were residing in the Southeastern United States along with their U.S. born children at the time of participation. Other inclusion criteria for participation in the study included the following: (a) all mothers were 18 years of age or older, (b) all mothers had at least one child to whom she had given birth since her arrival in the United States and who was between the ages of 8 and 18, (c) all mothers were the caretakers of the children who actually participated in the study. For the purpose of the study, participants were asked to provide information about their immigration experience.

Mothers with more than one child between the ages of 8 and 18 were asked to invite the oldest of their U.S.-born children to participate in the study. It was necessary that participants were able to read English or Spanish fluently to take part in the study. No translation services were provided for those who were not able to read and understand the instruments administered (e.g., persons who only speak an indigenous language were not be allowed to have someone translate the instruments for them).

The study sample was recruited by advertisement through various venues, including local Latino civic organizations, churches serving large numbers of Latinos, and referral by current study participants (i.e., snowball sampling). A bilingual flyer in English and Spanish (see Appendix A) which includes a brief overview of the purpose of the study, the criteria for participation, and researcher contact information was distributed to potential participants. As mother-child dyads committed to the study, they were asked to suggest names and contact information for other possible participants. No compensation was given for study participation.

Administration of Instruments

Informed consent and assent forms were made available to all found who met the criteria for the study. A scripted overview of the research process was read to all participants (Appendix B). The consent and assent forms were offered in both English and Spanish to ensure that participants were able to understand fully the terms of the study (see Appendices D-E). The informed consent document clearly stated the possibility of some re-traumatization due to recounting stories of past trauma. Appropriate referral information was given to all participants in case the need for psychotherapeutic services should arise in the future.

Mothers completing the consent forms were asked to complete the following instruments: Harvard Trauma Questionnaire (Mollica et al., 1992), the Brief Symptom Inventory (Derogatis

& Melisaratos, 1983), the Meaning of Life Questionnaire (Steger, Frazier, Oishi, & Kaler, 2006), and the Experiences in Close Relationships Questionnaire (Brennan, Clark, & Shaver, 1998). Children and adolescents were asked to complete the Child PTSD Symptoms Scale (Foa, Cashman, Jaycox, & Perry, 1997) and the Beck Depression Inventory for Youth-2nd edition (Beck, Beck, & Jolly, 2001). These assessments are attached in Appendices F-N (copyright information is available upon request). Demographic questionnaires in English or Spanish were administered to gather demographic and other personal data. Attempts were made to gather participants at a public place, such as a church or community center, to complete interviews and instruments by appointments.

Instrumentation

Maternal Trauma Measurement. The Harvard Trauma Questionnaire (Mollica et al., 1992) is structured so that users respond by checklist to questions about exposure to 17 potentially traumatic events and to PTSD symptomology. The instrument is divided into four different parts, namely a checklist of types of traumatic events experienced by the user (Part I), a description of the traumatic events deemed most significant by the user (Part II), items which inquire about head injury (Part III), and assessment of gravity of PTSD symptoms (Part IV). The current study focuses upon Part IV, but the entire instrument will be administered to participants. Part IV uses a Likert scale structured as follows: 1 = "Not at all", 2 = "A little", 3 = "Quite a bit", 4 = "Extremely".

The Harvard Questionnaire was originally written and validated in Cambodian, Laotian, and Vietnamese, primarily for non-Western refugees and asylum seekers emigrating to Western cultures (Mollica et al., 1992). Kleijn, Hovens, and Rodenburg (2001) conducted cross-cultural and cross-linguistic comparisons, finding both English and Spanish versions of the instrument to

have adequate psychometric properties to measure depression, anxiety, and posttraumatic stress disorder. Mollica et al. (1992) reported the original interrater reliability of the instrument for trauma events as $r = .91$ and as $r = .98$ for trauma symptoms. Test-retest reliability for both trauma events and trauma symptoms were measured over an 18 months period and measured at 0.89 and 0.92 respectively. Chronbach's alpha for the instrument was measured at 0.90 for trauma events and .96 for posttraumatic stress disorder symptoms.

In terms of validity, Mollica et al. (1992) reported a 0.78 sensitivity level in identifying those with posttraumatic stress disorder and 0.68 in identifying those without posttraumatic stress disorder. External validity was established through comparison of the Harvard Trauma Questionnaire to the Hopkins Symptoms Checklist, showing 89% accuracy in identifying participants with posttraumatic stress disorder and 84% accuracy in identifying those without posttraumatic stress disorder. Finally, convergent validity was established through correlation between number of traumatic events endured and severity of posttraumatic symptoms, with $r = .53$, $p < .0001$.

Maternal Depression Measurement. The Brief Symptom Inventory (BSI; Derogatis, 1983) consists of 53 items and uses self-reporting to assess psychological symptoms. With nine subscales (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism), the instrument prompts users with a Likert-scale to gauge the degree to which they experienced various symptoms in the last week. Users complete a 5-point rating of their level of experience with various symptoms in the past week, from 0 = "Not at all" to 4= "Extremely". For each subscale, the score is the mean of the specific items which comprise the subscale. The Global Severity Index (GSI) is a global subscale determined by calculating the mean all subscales.

All subscales of the BSI register with high internal consistency, ranging from 0.75 to 0.89 (Boulet & Boss, 1991). In terms of validity, Morlan and Tan (1998) compared the Brief Symptom Inventory to the clinician-rated Brief Psychiatric Rating Scale (Overall & Gorham, 1962) and found that scales measuring anxiety, depression, and hostility showed correlations of 0.46, 0.69, and 0.49 respectively, indicating high convergent validity. The Brief Symptoms Inventory has been used extensively in culturally diverse populations. Spanish and Italian translations of the Brief Symptom Inventory have exhibited reliability according to Biancosino et al. (2007) and Ruiperez, Ibanex, Lorene, Moro and Ortet (2001). For the Spanish version, all BSI scales indicated optimal indices of reliability: 0.91 on the depression scale; 0.79 on the phobic anxiety scale; 0.86 on the paranoid ideation scale; 0.87 on the obsession-compulsion scale; 0.77 on the somatization scale; and 0.70 on the hostility/aggressivity scale, and the internal consistency Cronbach's α coefficient was 0.95 (Ruiperez et al., 2001).

Maternal Meaning of Life Measurement. The Meaning in Life Questionnaire is used to measure the construct of meaning of life, which has been defined in a number of different ways, such as in terms of purposefulness and goal directedness (Ryff & Singer, 1998) or in terms of coherence found in life (Reker & Wong, 1988). The Meaning in Life Questionnaire consists of 10 items, divided into two subscales, Presence (MLQ-P) and Search (MLQ-S). Users respond to these 10 items using a 7-point Likert scale, with values of 1 = "absolutely untrue", 2 = "mostly untrue", 3 = "somewhat untrue", 4 = "can't say true or false", 5 = "somewhat true", 6 = "mostly true", and 7 = "absolutely true." The Presence subscale assesses the sense that individuals experience their lives as meaningful whereas the Search subscale assesses the drive individuals have toward finding meaning in their lives.

According to Steger, Frazier, Oishi, and Kaler (2006), both subscales show internal consistency between 0.86 and 0.88. The reliability measures for the Presence subscale and the Search subscales were 0.81 and 0.84 respectively during a first test of reliability and 0.86 and 0.92 respectively in a test reported by Steger, Frazier, Oishi, and Kaler. Test-retest reliability for both subscales was measured over a one month period and was found to be 0.70 for the Presence subscale and 0.73 for the Search subscale. To establish convergent validity, the Presence subscale was compared with the Purpose in Life Test (Crumbaugh & Maholick, 1964) and the Life Regard Index (Battista & Almond, 1973), and correlations from 0.58 to 0.74 were found between the Presence subscale and the Purpose in Life Test and the Life Regard Index, providing evidence for convergent validity. Convergent validity for the Search subscale was measured by comparing self-reports and informant reports on the subscale at two different time periods. Each measure produced significant correlations of 0.31 and 0.35, indicating convergent validity. Steger and Samman (2012) report translation and validation of the Meaning in Life Questionnaire in Spanish.

Maternal Attachment Style Measurement. The Experiences in Close Relationships Measure (ECR) (Brennan, Clark, & Shaver, 1998) is a 36-item self-report questionnaire designed to measure attachment style in adults by assessing avoidance of intimacy and anxiety about rejection. Divided into two scales, the Avoidance scale contains 18 Likert-scale items, and the Anxiety scale contains 18 Likert-scale items. Users endorse items with ratings ranging from 1 = "disagree strongly" to 7 = "agree strongly." The score for each subscale is generated by calculating the mean of the ratings given to all the items in that particular subscale. Thus, both subscale means may range from 1 to 7. The mean subscale scores can be used to located the user

in one of the four attachment style categories—secure, avoidant, anxious, and dismissing (Ainsworth, 1982; Bartholomew & Horowitz, 1991).

The ECR shows good internal consistency, with a Cronbach's α coefficient of .94 for the Avoidance scale and of .92 for the Anxiety scale. Criterion validity was assessed using the association between relationship status (in a relationship or not at the time of the study) and the Avoidance scales score given Hazan and Shaver (1987) previously reported Avoidance is associated with not being in a relationship. Non-relationship participants were significantly more avoidant than their currently involved counterparts, evidenced by statistically significant results of $t(1236) = 16.26$, $p < .001$.

The ECR has been translated into Spanish, with psychometric properties having been measured (Alonso-Arbiol, Balluerka, & Shaver, 2007). The Spanish version of the ECR shows good internal consistency, with Cronbach's α coefficients of .87 and .85 for the Avoidance scale and the Anxiety scale respectively. Criterion validity was also measured in the Spanish version of the ECR, with significant results found of $t(745) = 13.39$, $p < .001$.

Measurement of Child Trauma Symptomology. The Child PTSD Symptoms Scale (CPSS) (Foa, Cashman, Jaycox, & Perry, 1997) is a brief instrument used to measure severity of posttraumatic stress disorder in children and adolescents ages 8-18. Available in English and Spanish and consisting of 17 items in Part 1 and 7 items in Part 2, the CPSS is scored using a total PTSD score ranging from 0 to 51 as well as subscale scores. Part 1 of the questionnaire utilizes a Likert-type scale (possible responses 0 to 3) to prompt respondents to report frequency of experiences of certain PTSD criteria. Part 2 involves responding absent (0) or present (1) to questions about functional impairment. A cutoff of 15 or more is accepted as appropriate for determining PTSD (Pynoos et al., 1987).

Total and subscale scores have internal consistency ranging from .70 to .89. Test-retest reliability was .84, excellent for the total score, and good to excellent for the subscales (.85 for re-experiencing, .63 for avoidance and .76 for hyperarousal). The CPSS showed high convergent validity with correlation of .80 with the Child Posttraumatic Stress Reaction Index (Pynoos et al., 1987). Approximately 94% of cases were correctly classified by the CPSS subscales.

Measurement of Child Depression. The Beck Depression Inventory for Youth (BDI-Y; Beck, Beck, & Jolly, 2001) is a 20-item self-report instrument comprised of items from the five domains of negative views of the self, negative views of the world in general, hopelessness (referred to as "motivational"), and physiological and emotional symptoms of depression. Users of the BDI-Y rate each of the 20 statements on a 4-point Likert-scale of "never," "sometimes," "often," and "always," indicating how users feel the statements apply to them. "Never" is rated 0, and "always" is rated 3. One summated score is generated from the items on the scale, with summated scores ranging from 0 to 60.

Validation of scores on the BDI-Y found good internal consistency, ranging from .90 to .92 across gender and two broad age ranges (7 to 10-year olds and 11 to 14-year olds) (Beck et al., 2001). Test–retest reliabilities were measured at .74 and .93 over a 7-day period between administrations (Beck et al., 2001). In another study of psychiatric outpatients, internal consistency was measured at .94. Beck et al. (2001) and Steer, Kumar, Beck, and Beck (2001) found high convergent validity between the BDI-Y and the Children's Depression Inventory (CDI) scores, reporting .72 and .81, respectively.

Demographic Questionnaire. A demographic questionnaire (attached in Appendix C) was administered to all participant dyads to ascertain immigration documentation status and nationality of the mother, age of the child or adolescent, gender of child or adolescent, total

number of children born to the mother, number of years since initial immigration of the mother, and maternal marital status.

Variables

This study involves nine independent, predictor variables and two dependent, outcome variables, as listed below. The two dependent variables are quantitative, or continuous variables, and among the independent variables are both quantitative and qualitative, or categorical variables. Maternal documentation status had been included as an independent variable in the initial planning but was later omitted at the request of the Institutional Review Board of the University of Mississippi for the safety of participants.

Independent Variables

The following independent variables were assessed using the previously outlined instruments:

1. Marital status of mother (Categorical Variable; measured by questionnaire)
2. Meaning in life reported by the mother (Continuous Variables; measured by MLQ)
3. Attachment style of the mother (Continuous Variables; measured by ECR-R)
4. Depression in the mother (Continuous Variable; measured by BSI)
5. Maternal PTSD (Continuous Variable; measured by HTQ)
6. Total number of children of mother (Continuous Variable; measured by questionnaire)
7. Length of time since immigration (Continuous Variable; measured by questionnaire)
8. Age of the child or adolescent (Continuous Variable; measured by questionnaire)
9. Gender of the child or adolescent (Categorical Variable; measured by questionnaire)

Dependent Variables

The dependent variables of this study are measure of PTSD symptomology and measure of depression in second-generation Latino immigrant children and adolescents, rated by the CPSS and the BDI-Y respectively.

Multiple linear regression was utilized to explore the existence of a significant relationship between PTSD symptomology and depression in second-generation Latino immigrant children and adolescents.

Hypotheses

Hypothesis One

Levels of PTSD symptoms in U.S.-born Latino immigrant children and adolescents are not significantly predictable based on the factors of maternal PTSD symptom level, maternal depression level, meaning in life, attachment measure, number of years since initial immigration of mother, total number of children of the mother, age of the child, and gender of the child.

Hypothesis Two

Levels of depression symptoms in U.S.-born Latino immigrant children and adolescents are not significantly predictable based on the factors of maternal PTSD symptom level, maternal depression level, meaning in life, attachment measure, number of years since initial immigration of mother, total number of children of the mother, age of the child, and gender of the child.

Data Collection and Analysis

Data Collection

After approval was received from the Dissertation Committee and the Institutional Review Board of the University of Mississippi, recruitment of study participants commenced. Potential participants were administered the informed consent document and given an

opportunity to raise questions before receiving the instruments to complete. Brief relaxation exercises were executed with the children and youth participating to minimize the possibility of any re-traumatization from reading the items in the instruments. All data was collected in a confidential fashion, with no identifying information being requested of mothers or children. Each mother-child dyad was assigned an identification number used to match the instruments of mothers with the instruments of their children. The instruments were completed manually without computerized assistance in Spanish by the mothers and in English by the children/adolescents unless otherwise requested. Data was entered into SPSS 20.0 for appropriate statistical analysis.

Data Analysis

The focus of this study was to explore the existence of correlation between the independent variables (i.e. mother's marital status, mother's documentation status, meaning in life reported by the mother, attachment style of the mother, depression in the mother, maternal PTSD, total number of children of the mother, length of time since immigration, age of the child or adolescent, and gender of the child or adolescent) and the dependent variables of PTSD and depression. Beyond simply establishing existence or non-existence of correlation between the independent and dependent variables, this study aims to generate a prediction model usable in other cases. Because both dependent variables are continuous variables and a prediction model is sought, multiple linear regression will be used. Multiple linear regression is appropriate for statistical testing in which several independent variables are combined to predict one dependent variable value for a particular case (Tabachnick & Fidell, 2007). Because there are two dependent variables in this study, two prediction models with two distinct regression equations were constructed using the data collected. Bivariate correlation tests were conducted between all

predictors to test for multicollinearity. Correlations of r = 0.70 or higher occasioned the removal of one of the highly correlated predictors.

Three options exist for how independent variables can be entered into the regression equation, standard regression, sequential regression, and statistical regression (Tabachnick & Fidell, 2007). In standard regression, all variables are placed into the equation, and statistics are generated to describe the contribution of each independent variable in the prediction of the dependent variable. Sequential regression involves researchers theoretically and at times intuitively selecting the order in which independent variables are entered into the equation. Where there is overlap in contribution to the variability of the dependents between two independents, the contribution to variability will be assigned to the independent variable to which the researchers gave priority in the order of entry into the equation. Lastly, statistical regression involves including only the independent variables which contribute most to the prediction capacity and excluding independent variables not providing additional prediction power to independent variables already in the equation (Tabachnick & Fidell, 2007). Statistical regression offers an additional option, called backward statistical regression, to load all predictors into the model first and then eliminate one-by-one those not significant. This study employs backward statistical regression to reveal the prediction contributions of all independent variables listed in predicting PTSD symptomology and depression. Backward regression was used to avoid assigning any preference to predictors, as is done in sequential regression, due to lack of theoretical support for prioritizing predictors. Unlike standard regression, backward regression assesses for the contribution of significant predictors after non-significant predictors have already been removed.

Sample Size

Various software programs exist to execute power analysis for sample size calculations, such as G*Power 3.1. Based on results generated from performing a linear multiple regression (fixed model with R^2 increase) within the F tests group, the study requires a sample size of 107 cases at the $\alpha = .05$ level, for effect size $f^2 = 0.15$ and power of 0.79 for a total of 8 predictors. (Faul, Erdfelder, Buchner & Lang, 2009). Tabachnick and Fidell (2007) report 0.80 as a commonly desired level of statistical power. Tabachnick and Fidell (2007) suggest use of the formula $N \geq 50 + 8$ m, where N = sample size and m = number of predictors, to generated suggested sample size. In the case of 8 predictors, a sample size of 114 is appropriate.

Conclusion

The results generated from this study could offer direction to mental health practitioners, parents, school personnel, and others who work closely with the children of Latino immigrants in their efforts to promote mental health and wellness in these young people. Understanding particular predicting factors of PTSD creates the opportunity for educating families on how to put preventive measures in place. This study also serves as an invitation to the professional psychology community to review how PTSD is defined and understood, offering the possibility that transgenerational trauma, which does not fit into current PTSD criteria, is a phenomenon that merits wider recognition and discussion for treatment. Results of multiple regression data analyses are reported in the subsequent Results chapter.

CHAPTER 4: RESULTS

Introduction

The focus of this study pertains to the generation of a quantitative model for describing the influence that certain factors have on the transmission of trauma between generations in Latino immigrant families. Immigration can be a traumatic event at various stages of the process (Perez-Foster, 2001). Given the propensity for vicarious traumatization within families (Azoulay et al., 2005), attention is given to potential transferring of symptoms of posttraumatic stress disorder to offspring who did not directly experience the traumatic event of immigration. Multiple linear regression is the primary statistical tool used to test the above referenced quantitative model.

Overview of Results

During the data collection stage of the study, 107 cases of data were collected from 107 mother-child dyads, which fell slightly below the suggested sample size generated by the a priori test conducted using G*Power 3.1 as well as the formula for sample size of 114 proposed by Tabachnick and Fidell (2007). The sample was overwhelmingly Mexican in ethnic origin, with N = 90 dyads of Mexican origin (84.1%), N = 1 dyad of Honduran origin (0.9%), N = 14 dyads of Guatemalan origin (13.1%), N = 1 dyad of Salvadoran origin (0.9%), and N = 1 dyad unidentified in terms of origin (0.9%). The mean number of year mothers lived in the United States since their initial immigration was 14.58 (*SD* = 3.83, ranging from 8 to 26). Most of the mothers participating reporting being married (*M* = 69, 64.5 %), and the mean number of

children the mothers reported having was 3.01 (*SD* = 1.21, ranging from 1 to 7). All mothers participating completed the instruments in Spanish although English versions were available.

Of the 107 child participants, 47 (43.9%) were males, and 59 (55.1%) were females (the gender identification response was missing for one child participant). The mean age of children participating was 11.54 (*SD* = 2.92, ranging from 8 to 18). All children participating in the study completed the instruments in English although Spanish versions were made available. Profiles of the sample are located in Table 1 and Table 2.

Descriptive Statistics

Participants completed the Harvard Trauma Questionnaire (HTQ), the Depression Subscale score of the Brief Symptom Inventory (BSI), the Meaning in Life Questionnaire (MLQ), the Experiences in Close Relationships Questionnaire (ECR), the Child PTSD Symptoms Survey (CPSS), and the Beck Depression Inventory for Youth (BDI-Y). Descriptive statistics were calculated and are displayed in Table 3.

Listwise deletion was selected in SPSS to handle cases with missing data. In compliance with a stipulation made by the Institutional Review Board (IRB), the previously planned question about documentation status was eliminated from the demographic questionnaire for the safety of participants. While this could have been a highly significant predictor, inclusion of a question about documentation could have created apprehension in participants as well as lead to legal vulnerability for participants or other family members.

Among the study participants, 10.3% of the mothers met the criteria for clinical levels of PTSD on the PTSD index of the HTQ and 8.7% on the Trauma Index of the HTQ, using a cut-off score of 2.5 (Mollica et al., 1992). Of the data generated from child and adolescent participants, 58.3% demonstrated clinically significant levels of trauma on the CPSS, using a cut-

off score of 15 (Pynoos et al., 1987). No consensus was found in the literature about cut-off scores to indicate demonstrated clinical levels of depression for the BDI-Y or for the BSI Depression Subscale.

Table 1

Demographic Data for Sample (Categorical Variables)

Item Category	n	%
Country of Origin of Mothers		
Mexico	90	84.1
Honduras	1	0.9
Guatemala	14	13.1
El Salvador	1	0.9
Unidentified	1	0.9
Marital Status of Mothers		
Married	69	64.5
Divorced	3	2.8
Widowed	1	0.9
Single without Partner	5	4.7
Single with Partner	21	19.6
Unidentified	8	7.5
Gender of Child Participant		
Male	47	43.9
Female	59	55.1
Unidentified	1	0.9

Table 2

Sample Demographics (Continuous Variables)

Variable	M	*SD*	Range
Number of Years Since Initial Immigration	14.58	3.83	8-26
Total Number of Children	3.01	1.21	1-7
Age of Child (years)	11.54	2.92	8-18

Table 3

Descriptive Statistics for Instrument Scores

	N	*M*	*SD*	Skewness	Kurtosis
Independent variables					
DSM Index	107	1.65	0.57	0.90	0.41
HTQ Trauma Index	103	1.62	0.54	0.97	0.46
BSI Depression	97	0.92	0.91	1.29	1.27
MLQ—Presence	95	27.78	6.80	-1.30	1.78
MLQ—Search	93	21.01	10.18	-0.33	-1.33
ECR Attachment—Avoidance	79	3.24	0.98	0.11	0.55
ECR Attachment--Anxiety	81	3.62	1.26	0.25	-0.33
Dependent variables					
CPSS Trauma	104	17.92	10.96	0.23	-0.81
BDI-Y Depression	102	15.91	11.01	0.91	0.73

Outliers

Data plots were generated to identify extreme values in the data set. Extreme values can actually provide important insights about how variables interact but can also create challenges for creating prediction models (Tabachnick & Fidell, 2007). Using the boxplots generated by the Explore feature of SPSS 20.0, a total of 15 outliers from both dependent and independent continuous variables were removed from the dataset in order for analysis to proceed.

Assumptions of Multiple Regression

Multiple linear regression requires that several statistical assumptions be met for appropriate application to data, namely normality, independence of errors, homoscedasticity, and linearity (Tabachnick & Fidell, 2007). Normality of errors is required in dependent variables, which can be gauged using the Skewness Statistic generated by SPSS 20.0. Skewness for CPSS Score and BDI-Y Score were 0.23 and 0.91 respectively, falling within the range of 1.0 and -1.0, a long-acceptable range in the literature for acceptable and moderate skew, which implies normality (Bulmer, 1979). Independence of errors was gauged using the Durbin-Watson statistic generated from the regression analyses, using the range of 1.5 – 2.5 to indicate non-violation of the assumption. Residual statistics were requested in SPSS to verify the assumption of homoscedasticity, also known as equal variance of errors, was not violated. The issue of linearity was addressed using correlational analysis, which is discussed below.

Correlational Analysis

High correlations between predictor variables, called multicollinearity, can compromise the significance of regression coefficients. The assumption of linearity involves verifying that there is some linear relationship between independent variables and dependent variables. To

meet the requirement of linearity, a Pearson correlational analysis was conducted. This correlation analysis also was used to test for multicollinearity among predictors.

As the literature suggests, the childhood PTSD symptoms (CPSS) were highly correlated with childhood depression symptoms (BDI-Y) (Breslau, Davis, Peterson, & Schultz, 2000). However, no high correlations between childhood PTSD symptoms (CPSS) and the independent variables were discovered. Similarly, no high correlations between childhood depression symptoms and the independent variables were discovered. In terms of correlations between independent variables, there were several notable significant correlations. Consistent with the literature citing the strong association of PTSD with depression (Breslau, Davis, Peterson, & Schultz, 2000), both HTQ indices were highly correlated with BSI Depression Score. To avoid multicollinearity, the HTQ score was used as predictor without BSI Depression for all analyses.

MLQ-Presence was mildly, inversely correlated with both HTQ indices and the BSI Depression Score, and MLQ-Search was mildly, positively correlated with both HTQ indices and the BSI Depression Score. MLQ-Search was not used in regression modeling due to focus in hypotheses on gauging impact of positive presence of meaning in life. ECR-Anxiety was also mildly, positively correlated with both HTQ indices and the BSI Depression Score. There was also a very high correlation between age of child and the total number of years since the mother first immigrated. This correlation is easily explained in that mothers were encouraged to involve their oldest U.S.-born children in the study, who in many cases were born shortly after initial arrival. See Table 4 for a complete representation of inter-variable Pearson correlation results.

Multivariate Analysis

Backward statistical regression was applied to the following independent variables, with CPSS Score as dependent to test Hypothesis One and BDI-Y Score as dependent to test

Hypothesis Two: HTQ-Trauma Index, MLQ-Presence, ECR-Avoidance, ECR-Anxiety, Years Since Initial Immigration, Total Number of Children, Child Age, and Child Gender.

Hypothesis 1 stated that PTSD levels in US-born children of Latina immigrant women could not be predicted using as predictors traumatization symptom levels of the mother, depression symptom levels of the mother, meaning in life measures, attachment style levels, number of years since initial immigration of the mother, total number of children of the mother, age of the child, and gender of the child. This hypothesis was tested using multiple linear regression with the CPSS score as dependent variable. The Trauma Index of the HTQ was used in the listing of independent variables rather than the DSM Index because the Trauma Index is calculated using all the items of Part IV of the HTQ. The backward regression analysis resulted in a significant prediction model, with $F = 7.028$, $R^2 = 0.190$, $p = 0.02$. The Durbin-Watson statistic was 1.743. Individually significant predictors were gender of the child and total number of children of the mother. Table 5 contains the statistics generated from this analysis.

Hypothesis 2 stated that depression levels in U.S.-born children of Latina immigrant women could not be predicted using as predictors traumatization symptom levels of the mother, depression symptom levels of the mother, meaning in life measure, attachment level, number of years since initial immigration of the mother, total number of children of the mother, marital status of the mother, age of the child, and gender of the child. This hypothesis was tested using backward regression, with the depression subscale score of the BDI-Y employed as the dependent variable. As in the regression association with Hypothesis One, the Trauma Index of the HTQ was used as the measure of trauma symptomology of the mother. The analysis resulted in a significant prediction model, with $F = 5.257$, $R^2 = .149$, $p = .008$. The Durbin-Watson statistics was 2.054. Table 6 outlines that gender of child was the significant predictor variable.

Table 4

Pearson Correlation Coefficients Between Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Trauma Index	____										
2. BSI Depression	.746**	____									
3. MLQ—Presence	-.291**	-.355**	____								
4. MLQ—Search	.335**	.269*	-.199	____							
5. ECR—Avoidance	.232*	.276*	-.336*	.210	____						
6. ECR—Anxiety	.295**	.325**	-.265*	.338**	.081	____					
7. Years Since Immigration	.209*	.016	-.020	-.182	-.009	.259*	____				
8. Age of Child	.211*	.102	-.046	-.090	.016	.205	.654**	____			
9. Total Children	-.015	-.082	.028	-.002	-.151	.162	.134	.133	____		
10. CPSS	-.025	.068	-.020	-.057	-.094	.141	-.004	.072	.128	____	
11. BDI-Y	.038	.067	-.110	-.040	-.053	.093	.084	.128	.119	.691**	____

*--p < 0.05; **--p < 0.01

Table 5

Summary of Multiple Linear Regression for Predicting CPSS

Variable	B	SE(B)	β	*t*	*p*
Constant	-1.157	5.049		-.229	.819
Total Children	2.411	0.969	.290	2.489	.016**
Child Gender	7.190	2.426	.345	2.963	.004**

Table 6

Summary of Multiple Linear Regression for Predicting BDI-Y Score

Variable	B	SE(B)	β	*t*	*p*
Constant	-4.859	6.831		-.711	.480
Child Age	.778	.423	.220	1.839	.071
Child Gender	7.549	2.676	.337	2.821	.006*

Supplemental Analysis

An independent samples *t*-test showed a significant difference in BDI-Y depression scores between males and females ($p = .011$) but a non-significant difference in CPSS scores between males and females ($p = .063$). Consequently, separate regression models were generated for female child participants and male child participants with BDI-Y scores as the dependent variable. The regression involving only male child participants did not yield significant results, but the regression involving only female child participants resulted in a significant model, with $F = 5.661$, $R^2 = .150$, $p = .023$. Table 7 contains the relevant statistics of that model.

Table 7

Summary of Regression for Predicting BDI-Y Score of Female Child Participants

Variable	B	SE(B)	β	*t*	*p*
Constant	2.600	7.205		.361	.721
Child Age	1.447	.608	.388	2.379	.023*

Although both child participant instruments used in this study have been normed for children at the minimum participation age of 8 years, a great amount of variance may exist in development and maturation in child participants at the lower end of the age spectrum. Lack of proficiency in reading could have been a challenge for several child participants given the consistent documentation of poor reading levels in school children in many rural communities in Mississippi (Rutherford, Hillmer, & Parker, 2011). A lack of proficiency in reading might have affected the types of responses given since all participants were administered instruments with the expectation that they would self-complete. Consequently, separate multiple linear regression models were generated for child participants age 11 and above, who would be expected to read at a more proficient level than their younger counterparts. Limiting the model to child participants at age 11 and above, a significant model was generated for predicting CPSS, with $F = 5.224$, $R^2 = 0.427$, $p = 0.003$. The individual predictors indicating significance were MLQ-Presence, Years Since Initial Immigration, Total Number of Children of the Mother, and Child Gender, as detailed in Table 8.

Table 8

Summary of Regression for Predicting CPSS Score of Child Participants Age 11 and Above

Variable	B	SE(B)	β	*t*	*p*
Constant	28.721	13.916		2.064	.048*
MLQ-Presence	-.927	.325	-.434	-2.852	.008*
Yrs. Since Immig.	-.565	.484	-.174	-1.167	.253
Total No. of Child.	2.696	1.314	.304	2.052	.050*
Child Gender	10.454	3.340	.458	3.130	.004*

Table 9 contains the results of a comparable analysis using BDI-Y score as the dependent variable and limited to child participants ages 11 and above. The analysis yielded a model with $F = 5.202$, $R^2 = .435$, $p = .003$. Gender of child, Years Since Initial Immigration, ECR-Avoidance, and MLQ-Presence were identified as significant predictors.

Table 9

Summary of Regression for Predicting BDI-Y Score of Child Participants Age 11 and Above

Variable	B	SE(B)	β	*t*	*p*
Constant	65.710	20.746		3.167	.004*
MLQ-Presence	-1.176	.367	-.534	-3.205	.003*
ECR-Avoidance	-5.827	2.656	-.360	-2.194	.037*
Yrs. Since Immig.	-.754	.522	-.221	-1.445	.160
Child Gender	11.067	3.508	.466	3.155	.004*

Summary

Various significant regression models have identified certain independent variables as having predictive potential, namely Total Number of Children of the Mother, Gender of the Child, Age of the Child, MLQ-Presence, and ECR-Avoidance. Small R^2 values for some models indicate that the significant predictors in the model account for only a small part of the variability for the dependent variable. In terms of the supplemental analyses involving grouping child participants by gender and age, these analyses utilized a smaller number of cases, which diminishes statistical power. It is worth noting that the Trauma Index itself was not a significant predictor of CPSS score or BDI-Y score in any of the models generated. Trauma Index as a significant predictor of CPSS score or BDI-Y score would constitute some indication of transmission of trauma across generations.

CHAPTER 5: CONCLUSIONS

Introduction

As the phenomenon of immigration continues throughout the world due to economic conditions, war, discrimination and inequality, and other factors, immigration trauma will continue to affect immigrant communities in various aspects, including mental health (Benish-Weisman, 2009; Berger & Weiss, 2003). The impact of immigration trauma pervades not only the individual immigrant, but also the entire family system including children born after the physical immigration process (Beckerman & Corbett, 2008). The concept of transgenerational transmission of trauma offers some insights in the ongoing conversation about how traumatization of immigrants might influence the mental health of their children. Enhancing understanding of the process of transmission of the effects of traumatization from parent to child is critical to decreasing the occurrence through preventive efforts and to treating the occurrence once it has take place.

Qualitative and quantitative studies involving exploration and measurement of transgenerational transmission of trauma exist, but largely focusing upon the study of the concept as it pertains to Holocaust survivor families and war veteran families (Krysinkska & Lester, 2006; Pearrow & Cosgrove, 2009; Rosenheck & Fontana, 1998). There is controversy about whether traumatization is actually transmitted between generations in these two contexts, yet studies supporting the existence of transgenerational transmission of trauma suggest that this construct may be applicable to other populations (Frazier, West-Olatunji, St. Juste, & Goodman,

2009). This study was designed to examine connections between maternal trauma and child trauma in an effort to show whether traumatization of immigrant parents is correlated with trauma symptom levels in their children.

Discussion

The current study was conducted with hypotheses suggesting that transgenerational trauma would be detectable in Latino immigrant families and measurable and predictable through multiple linear regression. Convenience sampling was used to assemble a community sample of Latina mothers with their U.S. born children in various places throughout Mississippi and the Memphis, TN, metropolitan area. Degree of traumatization by symptoms reported was measured along with depression symptomology given the high correlation between PTSD and depression. The constructs of Meaning in Life and Attachment Style also were measured in the mothers to examine what role if any these two factors might have in the transmission of trauma across generations.

Given the use of multiple linear regression as the primary statistical tool, the hypotheses did not include any claim about causality, that PTSD and depression in Latino immigrants might cause PTSD and depression in their U.S.-born children. The hypotheses do measure whether the levels of PTSD and depression in U.S.-born children of Latino immigrant families might be highly correlated with comparable measures in their parents. This would suggest that U.S.-born children of Latino immigrant parents reporting high levels of PTSD and depression might be highly susceptible to experiencing their own traumatic events outside of the immigration experience of the family, such as community violence or sexual assault.

As the literature supports, this study revealed very high correlations between the Trauma Index of the HTQ and the BSI Depression Scale as well as between the CPSS Trauma Score and

the BDI-Youth Score, indicating high correlations between trauma and depression in all participants. As also supported by the literature, girls participating in the study reported significantly higher levels of depression (Walker et al., 2004; Stein, Walker, & Forde, 2000). Gender was clearly a significant factor in the phenomenon of transgenerational transmission of trauma in this study.

It was hypothesized in Hypothesis One that PTSD levels in US-born children of Latina immigrant women could not be predicted using as predictors traumatization symptom levels of the mother, depression symptom levels of the mother, meaning in life measures, attachment style levels, number of years since initial immigration of the mother, total number of children of the mother, age of the child, and gender of the child. Given the total number of children of the mother and gender of the child were significant predictors in the regression model generated, Hypothesis One, stated in null form, is rejected. Secondly, it was hypothesized in Hypothesis Two that depression levels in US-born children of Latina immigrant women could not be predicted using as predictors traumatization symptom levels of the mother, depression symptom levels of the mother, meaning in life measures, attachment style levels, number of years since initial immigration of the mother, total number of children of the mother, age of the child, and gender of the child. Given gender of the child was a significant predictor in the regression model generated to test this hypothesis, Hypothesis Two, stated in null form, also is rejected. There were statistically significant predictors of both PTSD levels on the CPSS and depression levels on the BDI-Y for Latino children and adolescents born in the U.S. to immigrant mothers.

The analyses have shown that gender is a predictor of both PTSD levels on the CPSS and depression levels on the BDI-Y for the child and adolescent participants, which is consistent with research suggesting girls experience both PTSD and depression at higher rates than boys (Green

et al., 1991; Nolen-Hoeksema & Girgus, 1994). Total Number of Children of the Mother contributed significantly to the model for prediction of CPSS trauma score with a positive coefficient, meaning children and adolescents from families with higher numbers of children register higher scores for trauma symptoms than those from families with lower numbers of children. Further investigation is needed to confirm and generalize this correlation between total number of children in the family and measure of child trauma symptomology, as well as to explain why the correlation exists. Future studies looking at correlations between psychological symptoms of Latina immigrant mother and symptoms of their U.S.-born children should examine how these correlations differ with gender and age of children.

Limitations of the Study

This study, which examined the transmission of immigration trauma between generations in a sample of Latino families living in the United States, supports the existence of some correlation between the psychological state of immigrant mothers and that of U.S.-born children. Multiple regression does not possess the power to establish causal relationships, but the construction of a moderate prediction model indicating particular factors influencing the relationship measured between maternal state and symptoms of offspring is possible. Various limitations to this study exist that likely affected the results reported from the data analysis.

First, limited sample size compromised the statistical power of the regression models. The overall number of cases reached the a priori suggested sample size. However, deletion of cases due to missing data reduced the number of cases used in the actual regression calculations. Other limitations of the study discussed below address the reasons for smaller than desired sample size.

Secondly trauma symptoms in the mothers were measured using the Harvard Trauma Questionnaire (HTQ), which was originally created and normed for persons affected by mass violence and displacement, namely Cambodian, Laotian, and Vietnamese refugees, being treated in a clinical setting (Mollica et al., 1992). The context for which the HTQ was written does not fit the situation or reason for migration for the majority of the sample involved in this study. However, there is no screening instrument available that uniquely measures immigration trauma. The construct of immigration trauma gives equal weight to traumatic events that happen pre-migration, during migration, immediately post-migration, and during long-term settlement. The HTQ does not include situations pertaining to long-term settlement, such as experience of racism, discrimination or isolation due to language barriers, or perceived insecurity due to legal status. Whereas political refugees are typically given asylum in the United States, undocumented immigrants often live in the shadows for fear of discovery and deportation. A trauma experience and symptoms instrument created and normed for non-refugee immigrants might have yielded different results.

This study only involved assessing trauma and depression symptoms in mothers, ignoring the contributions of the psychological distress of fathers to possible transmission of trauma and depression across generations in Latino families. Phares et al. (2005) report the routine exclusion of fathers from participation in pediatric psychology research as a weakness and common limitation to studies. Most studies pertaining to gender differences in how immigrants experience immigration trauma focus upon the unique vulnerability of women to domestic violence, sexual assault, and isolation and marginalization and the significantly higher levels of PTSD in women (Perez-Foster, 2001).

However, Thapa and Hauff (2005) introduce the idea that immigrant men experience different forms of psychological distress than immigrant women, such as distress due to denial of employment. Frustration with difficulties in protecting their families and providing for their families are similar issues that may cause more psychological distress in immigrant men than in women, particularly depending upon cultural outlook on gender roles. In this study the decision to focus only upon mothers was strictly logistical; nonetheless, 84.1 % (90 out of 107) of mothers participating reported being married or single with a partner, suggesting most families represented in the study do have some father or husband figure. Limiting participation to mothers in this study has rendered incomplete the picture crafted of the phenomenon of transgenerational transmission of trauma in Latino immigrant families, discounting the potential for fathers to contribute to psychological distress or to mitigate the effects of psychological distress in their children.

Due to the lack of solicitation of details about the direct trauma experiences of the children and adolescents involved, it is impossible to determine whether any trauma symptoms they reported are attributable to the immigration experience of their parents, their own direct trauma exposure, or to some other vicarious traumatization experience. Research reveals that Latino adolescents are more susceptible to witnessing community violence and to experiencing physical abuse or sexual assault than European American adolescents (Buka, Stichick, Birdthistle, & Earls, 2001). Not querying adolescent participants about their own direct traumatization or vicarious traumatization experiences constitutes a significant omission to understanding transgenerational transmission of trauma in this population.

Other factors in the study that may have hindered the emergence of more accurate results include literacy challenges with the target population, the existence of an environment of

mistrust on the part of the participants due to possible undocumented immigrant status, the presence of male significant others at some participation sites during the administration of the instruments, and cultural difference between the researcher and the participants.

According to Bennett et al. (2007), the number of Latina women with low literacy in both English and Spanish is growing in the U.S. population. A study conducted by these researchers found 34% of their sample read at below-adequate reading levels, with 90% of the sample having been born in Latin countries, most commonly Mexico. In the present study all psychological instruments were available in both Spanish and English. Some participants still had difficulty reading and comprehending the content, evidenced by a large number of questions asked about defining terms, not understanding the directions, feeling items were redundant because the distinctions between items were not grasped, and length of time needed for some participants to complete the instruments. Some difficulties might be attributable to poor translation from English or other languages into Spanish. One participant asked for clarification when completing the Experiences in Close Relationships Questionnaire (ECR) about the connotation of "intimacy." She held that the Spanish language understanding of "intimacy" pertained to sexual intimacy primarily as opposed to a more general understanding of intimacy that can include non-physical, emotional closeness. This uncertainty about context for the term intimacy could have implications for how all participants understood the term, or the ambiguity could have been more a matter of personal perspective for the individual who asked the question.

In addition to limitations due to literacy, fear that incriminating information may be released to authorities may have prevented some undocumented immigrants from participating as well as may have caused some to be reluctant to share some information. It was stressed in the oral presentation of the study as well as in the informed consent document that information about documentation status would not be solicited and that participation in the study was confidential,

with information being shared only with the researcher and faculty advisors. Some potential participants still questioned the purpose of the study and whether or not it might make their family vulnerable to law enforcement.

Because the study did not involve recruitment of fathers, husbands and fathers were very curious about the study. They were encouraged to read the informed consent and assent forms to understand the purpose of the research; however, some were inquisitive about the content of the psychological instruments. Some items in the instruments pertained to romantic partner issues, such as questions about domestic violence in the HTQ or about romantic partner intimacy in the ECR. Some mothers participating chose to allow men who were waiting to see the instruments, which could have compromised their responses.

Horst et al. (2012) cite mixed reviews about whether ethnic differences between clinicians and clients in psychotherapy significantly influence therapeutic rapport or the efficacy of interventions. In a qualitative study by Chang and Berk (2009), half the sample of ethnic/racial minority clients reported dissatisfaction with therapy involving 16 European American therapists due to lack of culture-specific knowledge while the other half of the sample reported having had a satisfactory experience and no perceptions of lack of cultural awareness. Wintersteen, Mensinger, and Diamond (2005) report a study of substance abusers in treatment in which gender-matched therapist-client dyads resulted in higher therapeutic alliances and higher program completion rates. Thus, there does exist in the literature some indications that gender and culture could negatively affect therapeutic outcomes. As an African American male researcher working with Latina mothers and their children, it is possible that cultural and gender differences affected response rates and willingness to participate in the research.

Implications for Clinical Practice and Counselor Education

Various clinical interventions have been empirically shown to work effectively in

treatment of Latino children and adolescents who exhibit symptoms of PTSD and symptoms of depression, including Trauma-Focused CBT for PTSD (Cohen, Deblinger, & Mannarino, 2004). Although greater empirical evidence is needed to show that trauma and depression in the parental generation might actually influence trauma and depression in offspring in Latino immigrant families, the possibility of some type of mental health interaction between generations suggests that clinicians should always take extensive family histories of mental health disturbance. These histories should give special attention to the stages of immigration trauma, i.e., premigration, in-transit, immediate resettlement, and acculturation, as they unfold in the lives of parents of child or adolescent clients. Whereas the initial identified client may be the child or adolescent, clinical services may be better delivered in a three-prong approach with individual services offered for the child or adolescent, family services, and also individual services offered for parents suffering from immigration-related trauma. This may require referrals.

Psychoeducational services to immigrant families also might be helpful in the prevention of transgenerational transmission of trauma. Upon initial arrival in the United States, both documented and undocumented Latino immigrants strive to establish connections with seemingly safe and comfortable networks, such as places of worship (Hirschman, 2004; Yang & Ebaugh, 2001). Worship places might become a forum for basic training about mental health, immigration trauma, and preventive strategies. In particular, there is a need to combat the stigma against mental health services that is prevalent in Latino culture (Nadeem et al., 2007). Recent immigrants may need to be educated on what mental health services entail. In the case of transgenerational trauma, psychoeducation should clearly convey to parents that they are not to blame for the phenomenon; rather, the objective should be to empower them to prevent the phenomenon or to mitigate its effects.

For counselor educators this study widens the understanding of PTSD. The DSM-5

(American Psychiatric Association, 2013) provides a lens for practitioners to use in diagnosing PTSD. The criteria clearly include exposure to a traumatic event. In the case of transgenerational trauma, it is possible that there is no directly traceable traumatic event experienced by the client. Counselors-in-training should be trained to be creative in the understanding of what constitutes exposure to a traumatic event. Counselors-in-training who have an understanding of immigration trauma would be able to view the experience of coming from an immigrant family as potentially but not necessarily traumatic. As the data analysis of this study indicates, certain factors, such as gender of the child or adolescent client, would provide additional markers for consideration that transmission of trauma across generations may have occurred.

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LIST OF APPENDICES

APPENDIX A:

INFORMATION FLYER (BILINGUAL)

Research Study/Estudio Scientifico

Trauma in Immigrant Families/Trauma en la Familias de Inmigrantes

Conducted by/Conducido por

Ricardo Phipps

University of Mississippi

Who: Hispanic/Latina mothers and their U.S.-born children are invited to participate.

Quien: Se invita a las madres Hispanas/Latinas y sus ninos y adolescentes nacidos en los Estados Unidos a participar.

For more information, contact Ricardo Phipps/Para mas informacion, contacten a Ricardo Phipps:

601-948-8867 or rmphipps@go.olemiss.edu.

An information session will be held on _____

at _____to offer more details.

Una sesion de informacion pasara _____ a

_____para ofrecer mas detalles.

APPENDIX B:

INTRODUCTORY INFORMATION SCRIPT (ENGLISH/SPANISH)

Introductory Information Script

Thank you for agreeing to hear this brief presentation about the research I am doing at the University of Mississippi. The research is about the impact of immigration upon the mental health of families, particularly Hispanic/Latino families. I am doing this research as the final stage of my doctoral education at the University of Mississippi. This topic is important because

- There is a large number of Hispanic/Latino persons immigrating to the United States, and mental health, including issues with depression, anxiety, and trauma, takes different forms in different cultural groups.
- Mental health professionals need to better understand how to work with Hispanic/Latino families and show greater sensitivity to unique cultural issues.

My study will involve mothers and their children. In order to participate, the mothers must have immigrated from a Spanish-speaking Latin American country and have children who were born in the United States and who are also willing to participate in the study. These children must be between age 8 and 18 and can be male or female.

If mothers and children from the same family choose to participate, you must be able to do basic reading (mothers in Spanish and children in English) and must be willing to complete some psychological assessments, designed to measure depression and the effects of exposure to trauma.

What I am planning to measure is how much the psychological state of mothers related to immigration influences the psychological state of their U.S. born children. So once you complete the assessments, I will take your responses and put them into a computer program to see if there are relationships between responses of the mothers and responses of the children.

Sometimes when people participate in studies like this, it causes them to remember painful things that happened which they had forgotten. This can be distressing. Know that you can stop answering the instruments at any time if you feel like it is too difficult or for any other reason you choose. If anyone feels the need to see a counselor after participation in the study, I will do my best to make referrals in your local area.

The instruments will take about 30-45 minutes total for the mothers to complete and about 15 minutes for the children and teens to complete. We will begin that now. If you would like to participate in the study but do not feel that now is a convenient time, please let me know and I will try to set up another time for you to do the assessments.

Are there any questions for those who plan to participate?

At this time, I ask that those who choose not to participate excuse themselves. For those participating, we will begin with asking each mother-child pair to complete a form with basic personal information and to sign forms indicating that you consent to participate.

Información introductoria Guión

Gracias por escuchar esta breve presentación sobre la investigación que estoy haciendo en la Universidad de Mississippi. La investigación es sobre el impacto de la inmigración sobre la salud mental de las familias, en particular las familias Hispanas/Latinas. Estoy haciendo esta investigación como etapa final de mis estudios de doctorado en la Universidad de Mississippi. Este tema es importante porque:

- Hay un gran número de personas Hispanas/Latinas que emigran a los Estados Unidos, y que tienen salud mental, incluyendo problemas con la depresión, la ansiedad y el trauma, los cuales toman distintas formas en diferentes grupos culturales.

- Profesionales de salud mental necesitan entender mejor cómo trabajar con las familias Hispanas/Latinas y mostrar más sensibilidad a las cuestiones culturales.

Mi estudio incluirá a las madres y sus hijos. Para poder participar, las madres deben haber emigrado de un país de habla hispana de Latino América y que tengan hijos que hayan nacido en los Estados Unidos y quienes también estén dispuestos a participar en el estudio. Estos niños deben tener entre 8 y 18 años y pueden ser hombres o mujeres.

Si las madres y los niños de la misma familia deciden participar, ustedes deben ser capaz de hacer una lectura básica (madres en español y los niños en Inglés) y deberán estar dispuestos a realizar algunas evaluaciones psicológicas, diseñadas para medir la depresión y los efectos de la exposición al trauma.

Lo que estoy planeando de saber es hasta qué punto el estado psicológico de las madres relacionado con la inmigración influye en el estado psicológico de sus hijos nacidos en los Estados Unidos. Así que una vez que usted complete las evaluaciones, tomaré sus respuestas y pondré dentro de un programa computacional para ver si existen relaciones entre las respuestas de las madres y las respuestas de los niños.

A veces, cuando las personas participan en estudios como este; esto les lleva a recordar cosas dolorosas que sucedieron, las cuales ya se habían olvidado. Esto puede molestar a la persona. Ustedes pueden dejar de contestar los cuestionarios en cualquier momento si ustedes sienten que es demasiado difícil o por cualquier otra razón que ustedes elijan. Si alguien siente la necesidad de ver a un consejero después de la participación en el estudio, voy a hacer mi mejor esfuerzo para hacer referencias en su área local.

Los cuestionarios requieren alrededor de 30-45 minutos en total para que las madres los completen y 15 minutos para los niños y adolescentes completen sus cuestionarios. Vamos a empezar ahora. Si usted desea participar en el estudio, pero no siente que ahora es el momento oportuno, por favor hágame saber y voy a tratar de establecer otro momento para que usted pueda hacer las evaluaciones.

¿Hay alguna pregunta para aquellos que planean participar?
En este momento, pido que los que optaron no participar se retiren. Para quienes participan, vamos a empezar con un formulario de información personal y una forma de consentimiento para cada pareja madre-hijo.

APPENDIX C:

DEMOGRAPHIC QUESTIONNAIRE (ENGLISH/SPANISH)

Transgenerational Trauma in Second Generation Latino Immigrant Children and Adolescents

Thank you for agreeing to participate in this study. This study is being conducted in fulfillment of requirements for the degree of Doctor of Counselor Education. Moreover, this research has important implications for the mental health of immigrant families in the United States. Mothers and their children and adolescent offspring are being invited to be a part of research that aims to offer insights about how trauma may be transmitted between caretakers and their children in immigrant communities in the United States. Your input is very valuable. All information you offer about yourself or your family will be held completely confidential. No identifying information will ever be shared beyond myself as principal researcher and my academic advisor at the University of Mississippi, Dr. Tabitha Young-Gast. Again, thank you for your participation. *Ricardo Phipps*

Dyad Identification Number _____

Mother

Country of Birth _____

Documentation Status (circle one) Undocumented Documented

("Documented" indicates that you have full, legal authorization to be in the United States at the time you are completing the instruments for this study.)

Number of Years Since Initial Immigration to US _____ _____
Years Months

Total Number of Children of Mother (born alive) _____

Marital Status of Mother (circle only one)

Married *Divorced* *Widowed* *Single (no partner)* *Single (with partner)*

Child/Adolescent

Place of Birth _____

Date of Birth (month/day/year) _____

Gender (circle one) Male Female

Trauma transgeneracional en la segunda generación de inmigrantes Latinos--Niños y Adolescentes

Gracias por aceptar participar en este estudio. Este estudio se ha realizado como requisito para el cumplimiento del grado de Doctor en Educación de Consejería. Por otra parte, esta investigación tiene importantes implicaciones para la salud mental de las familias inmigrantes en los Estados Unidos. Madres, hijos y adolescentes han sido invitados a ser parte de la investigación que tiene como objetivo de ofrecer información acerca de cómo el trauma puede ser transmitido entre los cuidadores de niños y los niños en las comunidades de inmigrantes en Estados Unidos. Su aportación es muy valiosa. Toda la información que ustedes ofrezcan acerca de ustedes mismos o de su familia será completamente confidencial. Esta información de identidad nunca será compartida con otras personas; solamente la tendremos yo, como principal investigador, y mi asesor académico de la Universidad de Mississippi, la Dr. Tabitha Young- Gast . Una vez más, gracias por su participación. *Ricardo Phipps*

Número de Identificación Dyad _____

Madre

País de nacimiento _____

Estado de documentación (circule uno) Documentada Indocumentada

("Documentado" significa que tiene plena autorización legal para estar en Estados Unidos al tiempo está completando los cuestionarios para este estudio.)

Número de años desde el inicio de inmigración a EE.UU._____ _____
Años Meses

Número total de niños de la Madre (nacidos vivos) _____

Estado matrimonial de la madre (circule sólo uno)

Casada Divorciada Viuda Soltera (sin pareja) Soltera (con la pareja)

Niños y Adolescentes

Lugar de nacimiento _____

Fecha de Nacimiento (mes / día / año) _____

Sexo (circule uno) Masculino Femenino

APPENDIX D:

ADULT INFORMED CONSENT FORM (SPANISH/ENGLISH)

Consentimiento Informado

La Trauma Transgeneracional de Segunda Generación los Niños Latinos y Adolescentes

Por favor, lea este documento de consentimiento con cuidado antes de decidirse a participar en este studio:

Objetivos del estudio:
Dada la dinámica actual de la inmigración en los Estados Unidos y el gran número de personas y familias con experiencias de inmigración y conexiones, interés por los efectos a largo plazo del trauma relacionado con la inmigración es un área crítica de interés para los profesionales de la salud mental. Los efectos del trauma van mucho más allá del individuo con la exposición al trauma, pero afectan a la familia. En otra investigación contextos ha apoyado la existencia de transmisión de los síntomas de trauma entre padres e hijos.

El presente estudio tiene dos objetivos principales . En primer lugar, este estudio tiene como objetivo proporcionar evidencia de una asociación significativa entre los síntomas del trastorno de estrés postraumático (y la depresión co -mórbida) en las madres que han sufrido un trauma de inmigración con experiencia y la demostración de los síntomas del trastorno de estrés postraumático (y la depresión co-mórbida) en la US- niños nacidos .

El segundo objetivo de esta investigación es desarrollar un modelo de predicción que permite a los profesionales de salud mental para predecir que Estados Unidos y nacieron los hijos de inmigrantes son más vulnerables a un trauma transgeneracional , con énfasis en el género , estilo de apego de la madre , la duración del año ya que la inmigración , y otros factores .

¿Cuál será su papel en el estudio:
Se le pedirá que complete una serie de cuatro cuestionarios en español . Si usted es incapaz de completar los cuestionarios por su cuenta, se le proporcionará asistencia para su realización. Ninos/jovenes de usted se le pediran que completen dos cuestionarios en ingles.

Tiempo requerido:
Participación durará aproximadamente una hora.

Riesgos y beneficios:
Existen posibles riesgos psicológicos asociados con la participación en este estudio. Hablar de acontecimientos traumáticos del pasado o responder a cuestionarios referentes a los traumas del pasado puede causar algo de malestar psicológico . En el caso de que la participación en el estudio tiene la ansiedad del sistema, información de referencia será dada por los servicios de salud mental en su área local. La información de referencia

también estará disponible para los participantes que pueden tener reacciones tardías a participar en el estudio.

En términos de beneficios directos , la participación en el estudio puede resultar en recuerdo de los recuerdos reprimidos que todavía pueden tener un efecto de su vida. La participación en el estudio puede convertirse en la ocasión para la búsqueda de servicios de salud mental que han sido previamente faltan. A nivel global , la participación en este estudio ayudará a mejorar el conocimiento acerca de lo que las necesidades de salud mental de las familias de inmigrantes latinos en los Estados Unidos.

Compensación:
No hay compensación por participar en este estudio.

Confidencialidad:
Su identidad se mantendrá confidencial durante todo el estudio. Su información se le asignará un número de código, en lugar de mantenerse con los propios datos.

A quien contactar sobre sus derechos como participante en una investigación en el caso de problemas:

Dr. Tabitha Young-Gast
School of Education
Guyton Hall
University of Mississippi
University, MS 38677
(662) 915-7816 phone
tlyoung@olemiss.edu

Dr. Mark Van Boening, IRB Chair
Institutional Review Board
100 Barr Hall
University of Mississippi
University, MS 38677
(662) 915-7482 phone
irb@olemiss.edu

Acuerdo Firmado:
He leído el procedimiento descrito anteriormente . Acepto voluntariamente participar en el procedimiento y de que he recibido una copia de esta descripción . [Si los participantes de la investigación no reciben una copia del formulario de consentimiento informado , deben entonces recibir una hoja informativa que incluye al menos el título de su estudio , junto con el su nombre e información de contacto, junto con la información de contacto de la “Institutional Review Board”.

Participante: _____ Fecha: _____

Investigador Principal: Ricardo Phipps Fecha: _____

Ricardo Phipps
2303 J. R. Lynch Street
Jackson, MS 39209
rmphipps@go.olemiss.edu

Informed Consent

Transgenerational Trauma in Second Generation Latino Children and Adolescents

Please read this consent document carefully before you decide to participate in this study.

Purpose of the research study:
Given the current dynamics of immigration in the United States and the large number of individuals and families with immigration experiences and connections, interest in long-range effects of immigration-related traumatization is a critical area of interest for mental health professionals. The effects of traumatization reach far beyond the individual with trauma exposure but impact the family. In other contexts research has supported the existence of transmission of trauma symptoms between parents and children.

The present study has two main objectives. First, this study aims to provide evidence of a significant association between posttraumatic stress disorder symptoms (and co-morbid depression) in mothers who have experienced immigration trauma and the demonstration of posttraumatic stress disorder symptoms (and co-morbid depression) in their U.S.-born children.

The second objective of this research is to build a prediction model that enables mental health professionals to predict which U.S.-born children of immigrants are most vulnerable to transgenerational trauma, with emphasis upon gender, attachment style of the mother, length of years since immigration, and other factors.

What will be your role in the study:
You will be asked to complete a series of four questionnaires in Spanish. If you are unable to complete the questionnaires on your own, you will be provided with assistance to complete them. Children of yours will be asked to complete questionnaires as well.

Time required:
Participation will take approximately one hour.

Risks and Benefits:
There are possible psychological risks associated with participating in this study. Discussing past traumatic events or responding to questionnaires referring to past traumas may cause some psychological distress. In the event that participating in the study does prompt anxiety, referral information will be given for mental health services in your local area. The referral information will also be available for participants who may have delayed reactions to participating in the study.

In terms of direct benefits, participating in the study may result in recall of repressed memories that may still have an effect of your life. Participation in the study can become the occasion for seeking mental health services that have previously been lacking. On a

global level, participation in this study will help improve awareness about what the mental health needs of Latino immigrant families in the United States.

Compensation:
There is no compensation for participation in this study.

Confidentiality:
Your identity will be kept confidential throughout the study. Your information will be assigned a code number, rather than maintained with any identifying information.

Whom to contact about your rights as a research participant in the case of concerns:

Dr. Tabitha Young-Gast
School of Education
Guyton Hall
University of Mississippi
University, MS 38677
(662) 915-7816 phone
tlyoung@olemiss.edu

Dr. Mark Van Boening, IRB Chair
Institutional Review Board
100 Barr Hall
University of Mississippi
University, MS 38677
(662) 915-7482 phone
irb@olemiss.edu

Signed Agreement:
I have read the procedure described above. I voluntarily agree to participate in the procedure and **I have received a copy of this description.** [If research participants do not receive a copy of their informed consent form, they should then receive an informational sheet including at least the title of your study, along with the your name and contact information, along with the contact information for the IRB.

Participant: _____ Date:_____

Principal Investigator: Ricardo Phipps Date: _____

Ricardo Phipps
2303 J. R. Lynch Street
Jackson, MS 39209
rmphipps@go.olemiss.edu

APPENDIX E:

CHILDREN/ADOLESCENT INFORMED ASSENT (ENGLISH/SPANISH)

CHILD INFORMED ASSENT

Oral Assent Script with Record of Child's (Aged 7-13) Response

I would like to ask you to help me with a project that I am doing at The University of Mississippi. I am trying to better understand how families are affected by immigrating to the United States. If you agree, you would answer some questions about how you feel and how you behave. It will take about 10 minutes.

What questions do you have about what you will do for me?

Will you do this?

Name: _____ Date: _____

Response: ❑ YES ❑ NO

CHILD INFORMED ASSENT
Involving Children (Aged 14-17)

Dear (*Participant*):

I would like to invite you to help me with a project that I am doing at The University of Mississippi.

The purpose of this project is to help me learn more about how families are affected by immigration to the United States, specifically how the effects of immigration trauma might be passed from parents to their children. No one will see your answers except my instructor and me, and I won't use your name in any reports.

If you take part in my research, you will fill out two questionnaires that ask you about your feelings and your behavior. It will take you about 10 minutes to finish.

You are free to quit this research at any time and I won't be upset with you. If you have any questions or concerns, please ask me now or call me at 601-613-4767. Thank you for your help.

Sincerely,

Ricardo Phipps

I agree to help with this research project. ❑ YES ❑ NO

Name: _____ Date: _____

NIÑO CONSENTIMIENTO INFORMADO

Guión asentimiento oral con registro de la respuesta del Niño (Edad 7-13)

Me gustaría pedirte que me ayudes con un proyecto que estoy haciendo en la Universidad de Mississippi. Estoy tratando de entender mejor cómo las familias se ven afectadas por emigrar a los Estados Unidos. Si estás de acuerdo, responderás algunas preguntas sobre cómo te sientes y cómo te comportas. Se tarda unos 10 minutos.

¿Qué preguntas tienes acerca de lo que vas a hacer por mí?

¿Lo harás?

Nombre: _____Fecha: _____

Respuesta: • SÍ • NO

_____

NIÑO CONSENTIMIENTO INFORMADO

Para los jovenes (de edades 14-17)

Estimado (participante):

Me gustaría invitarte para que me ayudes con un proyecto que estoy haciendo en la Universidad de Mississippi.

El propósito de este proyecto es ayudar a aprender más acerca de cómo las familias se ven afectadas por la inmigración a los Estados Unidos, específicamente cómo los efectos del trauma de inmigración pueden ser transmitidas de padres a hijos. Nadie verá sus respuestas, excepto mi instructor y yo, y no voy a utilizar tu nombre en ningún informe.

Si participas en mi investigación, te le llenes dos cuestionarios que preguntan acerca de tus sentimientos y tu comportamiento. Se puede recorrer en unos 10 minutos para terminar.

Eres libre de salir de esta investigación en cualquier momento y no se molesta contigo. Si tienes alguna pregunta o inquietud, por favor pregúntame ahora o llámame al 601-613-4767. Gracias por tu ayuda.

Atentamente,

Ricardo Phipps

Estoy de acuerdo en ayudar con este proyecto de investigación. • SÍ • NO

Nombre: _____ Fecha: _____

APPENDIX F:

HARVARD TRAUMA QUESTIONNAIRE (SPANISH)

INDICACIONES

INSTRUCTIONS

Nos gustaría conocer su historia personal y sus síntomas actuales. Esta información nos ayudará a mejorar su atención médica. Sin embargo, puede ser que algunas preguntas le molesten. Si así fuera, siéntase con libertad para no responder. Lo cual no afectará su tratamiento. Sus respuestas serán guardadas de forma confidencial.

We would like to know about your past history and present symptoms.This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. The answer to the questions will be kept confidential.

Parte 1: Sucesos Traumáticos

Trauma Events

Indique, por favor, si ha tenido la experiencia de alguno de los siguientes sucesos (Señale SI ó NO)
Please indicate whether you have experienced any of the following events (Check YES or NO)

N°	**Suceso** (Event)	**SI** YES	**NO** NO
1.	**Falta de hogar** Lack of shelter		
2.	**Falta de comida o agua** Lack of food or water		
3.	**Mala salud sin acceso a atención médica** Ill health without access to medical care		
4.	**Confiscación o destrucción de propiedad personal** Confiscation or destruction of personal property		
5.	**Situación de guerra (p.ej. ataque de granada o bomba)** Combat situation (e.g. shelling and grenade attacks)		
6.	**Usado como escudo humano** Used as a human shield		
7.	**Expuesto a fuego de francotirador implacable y frecuente** Exposure to frequent and unrelenting sniper fire		
8.	**Evacuación forzada en condiciones de peligro vital** Forced evacuation under dangerous conditions		
9.	**Golpeado fisicamente** Beating to the body		

N°	**Suceso** Event	**SI** YES	**NO** NO
10.	**Violación sexual** Rape		
11.	**Otros tipos de abuso sexual o humillación sexual** Other types of sexual abuse or sexual humiliation		
12.	**Acuchillado o cortado con hacha** Knifing or axing		
13.	**Tortura, (p.ej., estando detenido le causaron sistemática y deliberadamente sufrimiento físico o mental)** Torture (i.e., while in captivity you received deliberate and systematic infliction of physical or mental suffering)		
14.	**Daño físico serio por situación de combate (p.ej., metralla, quemadura, herida de bala, puñalada, etc.) o mina terrestre** Serious physical injury from combat situation (i.e., shrapnel, burn, bullet wound, stabbing, etc.) or landmine		
15.	**Encarcelamiento** Imprisonment		
16.	**Trabajo forzado (como animal o esclavo)** Forced labor (like animal or slave)		
17.	**Estorsión o robo** Extortion or robbery		
18.	**Lavado de cerebro** Brainwashing		
19.	**Forzado a esconderse** Forced to hide		
20.	**Secuestrado** Kidnapped		
21.	**Otra separación forzada de miembros de su familia** Other forced separation from family members		
22.	**Forzado a encontrar y enterrar cuerpos** Forced to find and bury bodies		
23.	**Aislamiento forzado de los demás** Enforced isolation from others		
24.	**Presente mientras alguien buscaba personas o cosas en su casa (o lugar donde estaba viviendo)** Present while someone searched for people or things in your home (or place where you were living)		
25.	**Forzado a cantar canciones que usted no quería cantar** Forced to sing songs you did not want to sing		
26.	**Alguien fue forzado a delatarle a usted y le puso en situación de riesgo de muerte o daño** Someone was forced to betray you and place you at risk of death or injury		
27.	**Encerrado en casa porque había peligro afuera** Confined to home because of danger outside		

N°	**Suceso** Event	**SI** YES	**NO** NO
28.	**Le impidieron enterrar a alguien** Prevented from burying someone		
29.	**Forzado a profanar o destruir los cuerpos o tumbas de personas fallecidas** Forced to desecrate or destroy the bodies or graves of deceased persons		
30.	**Forzado a herir físicamente a miembros de la familia, o amigos** Forced to physically harm family member, or friend		
31.	**Forzado a herir fisicamente a alguien que no era familiar ni amigo** Forced to physically harm someone who is not family or friend		
32.	**Forzado a destruir pertenencias o propiedades de otros** Forced to destroy someone else's property or possessions		
33.	**Forzado a delatar a algún miembro de la familia o amigo, poniédole en situación de riesgo de muerte o daño** Forced to betray family member, or friend placing them at risk of death or injury		
34.	**Forzado a delatar a alguien que no era familiar ni amigo poniéndolo en riesgo de daño o muerte** Forced to betray someone who is not family or friend placing them at risk of death or injury		
35.	**Asesinato o muerte, debida a violencia, de esposa/o** Murder, or death due to violence, of spouse		
36.	**Asesinato o muerte, debida a violencia, de hijo/a** Murder, or death due to violence, of son or daughter		
37.	**Asesinato o muerte, debida a violencia, de otro miembro de la familia o amigo** Murder, or death due to violence, of other family member or friend		
38.	**Desaparición o secuestro de esposa/o** Disappearance or kidnapping of spouse		
39.	**Desaparición o secuestro de hijo/a** Disappearance or kidnapping of son or daughter		
40.	**Desaparición o secuestro de otro miembro de la familia o amigo** Disappearance or kidnapping of other family member or friend		
41.	**Daño físico serio de un miembro de la familia o amigo debido a la situación de combate o mina terrestre** Serious physical injury of family member or friend due to combat situation or landmine		
42.	**Testigo de golpes en la cabeza o cuerpo** Witness beatings to head or body		

N°	**Suceso** Event	**SI** YES	**NO** NO
43.	**Testigo de tortura** Witness torture		
44.	**Testigo de muerte/asesinato** Witness killing/murder		
45.	**Testigo de violación o abuso sexual** Witness rape or sexual abuse		
46.	**Alguna otra situación que daba mucho miedo o en la que sintió que su vida estaba en peligro.** **Especifique:** Any other situation that was very frightening or in which you felt your life was in danger. Specify:		

Part 2: Descripción Personal

Personal Description

Indique, por favor, qué sucesos de los que haya vivido considera más dañinos o terribles. Especifique, por favor, dónde y cuándo ocurrieron estos sucesos.
Please indicate what you consider to be the most hurtful or terrifying events you have experienced, if any. Please specify where and when these events occurred.

_____

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En su situación actual de vida (p. Ej., campo de refugiados, llegada a un país nuevo, vuelta del exilio, etc.) ¿cuál es el peor suceso que le ha ocurrido a usted, si es diferente del anterior? Especifique, por favor, dónde y cuándo ocurrió este suceso.
Under your current living situation (i.e. refugee camp, country of resettlement, returned from exile, etc.) what is the worst event that has happened to you, if different from above? Please specify where and when these events occurred.

_____

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_____

Part 3: Daño cerebral (traumatismo craneoencefálico)
Head Injury

Si su respuesta fue afirmativa para los siguientes sucesos traumáticos, indique, por favor, si perdió la conciencia y por cuánto tiempo.
For self report: If you answer yes to the following trauma events, please indicate if you lost consciousness and for how long.

		¿Tuvo la experiencia de…? Experienced?		**¿Perdió la conciencia?** Loss of consciousness?		**Si es sí ¿Por cuánto tiempo?** If Yes, for how long?	
N°		**Sí** Yes	**No** No	**Sí** Yes	**No** No	**Horas** Hours	**Minutos** Minutes
๑๑	**Golpes en la cabeza** Beatings to the head						
๒๑	**Asfixia o estrangulamiento** Suffocation or strangulation						
๓๑	**Casi fue ahogado** Near drowning						
๔๑	**Otro tipo de daños en la cabeza (p.e. metralla, quemaduras, etc.)** Other types of injury to the head (e.g. shrapnel, burns, etc.)						
๕๑	**Hambre** Starvation						

Si respondió sí al 5.: **Peso normal: _____** **Peso por hambre:_____**

(If Yes to 5.: Normal weight:_____ Starvation weight:_____)

Si respondió sí al 5.:
¿Estuvo cerca de la muerte por hambre? **Yes:_____ No:_____**

(If Yes to 5.:, Were you near death due to starvation? Yes:_____ No:_____)

Part 4: Síntomas de Trauma

Trauma Symptoms

La lista muestra síntomas que las personas pueden tener después de vivir sucesos dañinos o terribles. Por favor, lea cada síntoma atentamente e indique cuánto le ha molestado durante la semana pasada.

For self report: The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

		(1) **Nunca** (Not at all)	(2) **Un poco** (A little)	(3) **Bastante** (Quite a bit)	(4) **Mucho** (Extremely)
1.	**Pensamientos o recuerdos recurrentes de los sucesos más terribles y dañinos** Recurrent thoughts or memories of the most hurtful or terrifying events				
2.	**Sentimiento de que el suceso está ocurriendo de nuevo** Feeling as though the event is happening again				
3.	**Pesadillas recurrentes** Recurrent nightmares				
4.	**Sentimiento de indiferencia o distanciamiento de los demás** Feeling detached or withdrawn from people				
5.	**Incapacidad de sentir emociones** Unable to feel emotions				
6.	**Se siente nervioso (aprensivo, asustadizo), se sobresalta facilmente** Feeling jumpy, easily startled				
7.	**Dificultad de concentración** Difficulty concentrating				
8.	**Problemas de sueño** Trouble sleeping				
9.	**Sentimiento (se siente en estado) de alerta** Feeling on guard				

10.	**Se siente irritable o tiene ataques de ira** Feeling irritable or having outbursts of anger				
11.	**Evita actividades que le recuerdan el suceso dañino o traumático** Avoiding activities that remind you of the traumatic or hurtful event				
12.	**Incapacidad para recordar partes de los sucesos más dañinos o traumáticos** Inability to remember parts of the most hurtful or traumatic events				
13.	**Ha perdido interés por las actividades diarias** Less interest in daily activities				
14.	**Siente que no tiene futuro** Feeling as if you don't have a future				
15.	**Evita pensamientos o sentimientos asociados a los sucesos dañinos o traumáticos** Avoiding thoughts or feelings associated with the traumatic or hurtful events				
16.	**De repente, reacción física o emocional, cuando recuerda los más dañinos y traumáticos sucesos** Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events				
17.	**Siente que tiene menos capacidad que antes** Feeling that you have less skills than you had before				
18.	**Tiene dificultades para afrontar nuevas situaciones** Having difficulty dealing with new situations				
19.	**Se siente agotado** Feeling exhausted				
20.	**Dolor corporal** Bodily pain				
21.	**Preocupado por problema(s) físico(s)** Troubled by physical problem(s)				

22.	**Memoria escasa** Poor memory				
23.	**Se ha dado cuenta o le han dicho que ha hecho alguna cosa que no recuerda** Finding out or being told by other people that you have done something that you cannot remember				
24.	**Dificultad para prestar atención** Difficulty paying attention				
25.	**Siente como si estuviera dividido en dos personas y una estuviera mirando lo que hace la otra** Feeling as if you are split into two people and one of you is watching what the other is doing				
26.	**Se siente incapaz de hacer planes diarios** Feeling unable to make daily plans				
27.	**Sentimiento de culpa por las cosas que han sucedido** Blaming yourself for things that have happened				
28.	**Sentimiento de culpa por haber sobrevivido** Feeling guilty for having survived				
29.	**Falta de esperanza** Hopelessness				
30.	**Sentimiento de vergüenza por el suceso dañino o traumático que le ha ocurrido** Feeling ashamed of the hurtful or traumatic events that have happened to you				
31.	**Sentimiento de que la gente no entiende lo que le ha ocurrido** Feeling that people do not understand what happened to you				
32.	**Sentimiento de que otros son hostiles con usted** Feeling others are hostile to you				
33.	**Sentimiento de que usted no tiene en quien confiar** Feeling that you have no one to rely upon				

34.	**Sentimiento de que alguien de su confianza le ha traicionado** Feeling that someone you trusted betrayed you				
35.	**Sentimiento de humillación por su experiencia** Feeling humiliated by your experience.				
36.	**Sentimiento de desconfianza en otros** Feeling no trust in others.				
37.	**Sentimiento de impotencia para ayudar a otros** Feeling powerless to help others.				
38.	**Pérdida de tiempo pensando por qué estos sucesos le ocurrieron a usted** Spending time thinking why these events happened to you				
39.	**Sentimiento de que usted es el único que sufrió estos sucesos** Feeling that you are the only one that suffered these events.				
40.	**Sentimiento de necesidad de venganza** Feeling a need for revenge.				

APPENDIX G:

HARVARD TRAUMA QUESTIONNAIRE (ENGLISH VERSION)

INSTRUCTIONS

We would like to ask you about your past history and present symptoms. This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. The answer to the questions will be kept confidential.

PART 1: TRAUMA EVENTS

Please indicate whether you have experienced any of the following events (check YES or NO)

	Trauma Events	YES	NO
1.	Lack of shelter		
2.	Lack of food or water		
3.	Ill health without access to medical care		
4.	Confiscation or destruction of personal property		
5.	Combat situation (e.g. shelling and grenade attacks)		
6.	Forced evacuation under dangerous conditions		
7.	Beating to the body		
8.	Rape		
9.	Other types of sexual abuse or sexual humiliation		
10.	Knifing or axing		
11.	Torture, i.e., while in captivity you received deliberate and systematic infliction of physical or mental suffering		
12.	Serious physical injury from combat situation or landmine		

	Trauma Events	YES	NO
13.	Imprisonment		
14.	Forced labor (like animal or slave)		
15.	Extortion or robbery		
16.	Brainwashing		
17.	Forced to hide		
18.	Kidnapped		
19.	Other forced separation from family members		
20.	Forced to find and bury bodies		
21.	Enforced isolation from others		
22.	Someone was forced to betray you and place you at risk of death or injury		
23.	Prevented from burying someone		
24.	Forced to desecrate or destroy the bodies or graves of deceased persons		
25.	Forced to physically harm family member, or friend		
26.	Forced to physically harm someone who is not family or friend		
27.	Forced to destroy someone else's property or possessions		
28.	Forced to betray family member, or friend placing them at risk of death or injury		
29.	Forced to betray someone who is not family or friend placing them at risk of death or injury		
30.	Murder, or death due to violence, of spouse		

	Trauma Events	YES	NO
31.	**Murder, or death due to violence, of child**		
32.	**Murder, or death due to violence, of other family member or friend**		
33.	**Disappearance or kidnapping of spouse**		
34.	**Disappearance or kidnapping of child**		
35.	**Disappearance or kidnapping of other family member or friend**		
36.	**Serious physical injury of family member or friend due to combat situation or landmine**		
37.	**Witness beatings to head or body**		
38.	**Witness torture**		
39.	**Witness killing/murder**		
40.	**Witness rape or sexual abuse**		
41.	**Another situation that was very frightening or in which you felt your life was in danger.** **Specify:**		

PART 2: PERSONAL DESCRIPTION

Please indicate what you consider to be the most hurtful or terrifying events you have experienced, if any. Please specify where and when these events occurred.

_____

_____

_____

_____

_____

_____

_____

_____

Under your current living situation (i.e. refugee camp, country of resettlement, returned from exile, etc.) what is the worst event that has happened to you, if different from above. Please specify where and when these events occurred.

_____

_____

_____

_____

_____

_____

_____

PART 3: HEAD INJURY

If you answer yes to the following trauma events, please indicate if you lost consciousness and for how long.

	Experienced		Loss of consciousness?		If Yes, for how long?	
	Yes	No	Yes	No	Hours	Minutes
1. Beatings to the head						
2. Suffocation or strangulation						
3. Near drowning						
4. Other types of injury to the head (e.g. shrapnel, burns, etc.)						
5. Starvation						
If Yes: Normal weight: Starvation weight:						
If Yes: Were you near death due to starvation? Yes: No						

PART 4: TRAUMA SYMPTOMS

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you <u>in the past week</u>.

	Trauma Symptoms	(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
1.	Recurrent thoughts or memories of the most hurtful or terrifying events				
2.	Feeling as though the event is happening again				
3.	Recurrent nightmares				
4.	Feeling detached or withdrawn from people				
5.	Unable to feel emotions				
6.	Feeling jumpy, easily startled				
7.	Difficulty concentrating				
8.	Trouble sleeping				
9.	Feeling on guard				
10.	Feeling irritable or having outbursts of anger				
11.	Avoiding activities that remind you of the traumatic or hurtful event				

	Trauma Symptoms	(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
12.	**Inability to remember parts of the most hurtful or traumatic events**				
13.	**Less interest in daily activities**				
14.	**Feeling as if you don't have a future**				
15.	**Avoiding thoughts or feelings associated with the traumatic or hurtful events**				
16.	**Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events**				
17.	**Feeling that you have less skills than you had before**				
18.	**Having difficulty dealing with new situations**				
19.	**Feeling exhausted**				
20.	**Bodily pain**				
21.	**Troubled by physical problem(s)**				
22.	**Poor memory**				
23.	**Finding out or being told by other people that you have done something that you cannot remember**				
24.	**Difficulty paying attention**				
25.	**Feeling as if you are split into two people and one of you is watching what the other is doing**				
26.	**Feeling unable to make daily plans**				

	Trauma Symptoms	(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
27.	**Blaming yourself for things that have happened**				
28.	**Feeling guilty for having survived.**				
29.	**Hopelessness.**				
30.	**Feeling ashamed of the hurtful or traumatic events that have happened to you**				
31.	**Feeling that people do not understand what happened to you.**				
32.	**Feeling others are hostile to you**				
33.	**Feeling that you have no one to rely upon**				
34.	**Feeling that someone you trusted betrayed you**				
35.	**Feeling humiliated by your experience.**				
36.	**Feeling no trust in others.**				
37.	**Feeling powerless to help others.**				
38.	**Spending time thinking why these events happened to you**				
39.	**Feeling that you are the only one that suffered these events.**				
40.	**Feeling a need for revenge.**				

APPENDIX H

BRIEF SYMPTOM INVENTORY (SPANISH VERSION)

INSTRUCCIONES

La prueba BSI consiste de una lista de problemas que la gente algunas veces tiene. Por favor léalas cuidadosamente y encierre en un círculo el número que mejor describa CUANTO HA ESTADO MOLESTO O HA SUFRIDO POR ESE PROBLEMA DURANTE LOS ULTIMOS 7 DIAS INCLUYENDO EL DIA DE HOY. Encierre en un círculo sólo un número por cada problema (0 1 2 3 4) y no se salte ninguno. Si decide cambiar su respuesta, ponga una X en su respuesta primera y encierre en un círculo su respuesta nueva (0 X 2 3 4). Antes de comenzar, lea el ejemplo y si tiene alguna pregunta por favor hágala.

EJEMPLO

0 = Nada 1 = Un poco 2 = Moderadamente 3 = Bastante 4 = Mucho

INDIQUE CUANTO SE HA SENTIDO MOLESTO POR:

Dolores en el cuerpo 0 1 2 3 4

0 = Nada 1 = Un poco 2 = Moderadamente 3 = Bastante 4 = Mucho

INDIQUE CUANTO SE HA SENTIDO MOLESTO POR:

1. Nerviosismo o temblor 0 1 2 3 4
2. Sensación de desmayo o mareos 0 1 2 3 4
3. La idea de que otra persona puede controlar sus pensamientos 0 1 2 3 4
4. El sentimiento de que otros son culpables de la mayoría de sus problemas 0 1 2 3 4
5. Dificultad para recordar cosas 0 1 2 3 4
6. Sentirse fácilmente molesto o irritado 0 1 2 3 4
7. Dolores en el corazón o en el pecho 0 1 2 3 4
8. Sentirse asustado en espacios abiertos o en la calle 0 1 2 3 4
9. Pensamientos de poner fin a su vida 0 1 2 3 4
10. Sentir que no se puede confiar en la mayoría de la gente 0 1 2 3 4
11. Falta de apetito 0 1 2 3 4
12. Sustos repentinos y sin razón 0 1 2 3 4
13. Explosiones de enojo que no puede controlar 0 1 2 3 4
14. Sentirse solo aun cuando está acompañado de gente 0 1 2 3 4
15. Sentirse impedido de hacer las cosas 0 1 2 3 4
16. Sentirse solo 0 1 2 3 4
17. Sentimientos de tristeza 0 1 2 3 4
18. No sentir interés por las cosas 0 1 2 3 4
19. Sentirse con miedo 0 1 2 3 4
20. Sus sentimientos son fácilmente heridos 0 1 2 3 4
21. Sentir que la gente no es amigable o que usted no le cae bien 0 1 2 3 4
22. Sentirse inferior a los demás 0 1 2 3 4
23. Náuseas o malestar en el estómago 0 1 2 3 4
24. Sentir que otros lo miran o hablan de usted 0 1 2 3 4
25. Dificultad para dormirse 0 1 2 3 4
26. Tener que revisar varias veces lo que hace 0 1 2 3 4
27. Dificultad para tomar decisiones 0 1 2 3 4

Test Administrator: To begin scoring, turn off this conference and follow the directions in the Manual.

Pase a la página siguiente.

0 = Nada 1 = Un poco 2 = Moderadamente 3 = Bastante 4 = Mucho

INDIQUE CUANTO SE HA SENTIDO MOLESTO POR:

28. Tener miedo de viajar en autobuses, trenes o subterráneos/metros 0 1 2 3 4
29. Falta de aire 0 1 2 3 4
30. Cambios repentinos de temperatura en el cuerpo 0 1 2 3 4
31. Evitar ciertas cosas, lugares o actividades porque le ocasionan miedo 0 1 2 3 4
32. Tener la mente en blanco 0 1 2 3 4
33. Adormecimiento u hormigueo en ciertas partes del cuerpo 0 1 2 3 4
34. La idea de que usted debe ser castigado por sus pecados 0 1 2 3 4
35. Sentirse sin esperanza en el futuro 0 1 2 3 4
36. Dificultad para concentrarse 0 1 2 3 4
37. Sentirse débil en partes del cuerpo 0 1 2 3 4
38. Sentirse tenso o alterado 0 1 2 3 4
39. Pensar en la muerte o en morirse 0 1 2 3 4
40. Tener la necesidad de golpear, herir, o hacerle daño a alguien 0 1 2 3 4
41. Sentir la necesidad de romper o arrojar cosas 0 1 2 3 4
42. Sentirse muy consciente de sí mismo en presencia de otros 0 1 2 3 4
43. Sentirse incómodo al estar en grupos grandes, como cuando va de compras o en el cine 0 1 2 3 4
44. Nunca sentirse cerca de otra persona 0 1 2 3 4
45. Ataques de terror o pánico 0 1 2 3 4
46. Entrar en frecuentes discusiones 0 1 2 3 4
47. Sentirse nervioso cuando lo dejan solo 0 1 2 3 4
48. Los demás no le reconocen adecuadamente sus logros 0 1 2 3 4
49. Sentirse tan inquieto que no puede permanecer sentado 0 1 2 3 4
50. Sentir que usted no vale nada 0 1 2 3 4
51. Sentir que la gente se aprovechará de usted si se lo permite 0 1 2 3 4
52. Sentimientos de culpabilidad 0 1 2 3 4
53. La idea de que algo anda mal con su mente 0 1 2 3 4

Pase a la página siguiente y siga las instrucciones para completar la información adicional.

APPENDIX I:

MEANING IN LIFE QUESTIONNAIRE (SPANISH VERSION)

MLQ Por favor, dedique un momento a pensar lo que le hace sentir que su vida es importante y tiene un significado. Con esas ideas en mente, por favor, responda a las siguientes cuestiones tan sincera y exactamente como pueda. Y tenga en cuenta que se trata de cuestiones muy subjetivas, que no tienen una respuesta correcta o incorrecta. Responda utilizando la siguiente escala

Totalmente falso	Bastante falso	Mas bien falso	No sé. Ni verdadero ni falso	Mas bien verdadero	Bastante verdadero	Totalmente verdadero
1	2	3	4	5	6	7

1. _____Comprendo el significado de mi vida.
2. _____Busco algo que me haga sentir que mi vida tiene sentido.
3. _____Siempre estoy buscando el sentido de mi vida..
4. _____Mi vida tiene un significado muy claro.
5. _____Tengo algunas buenas intuiciones acerca de lo que le da sentido a mi vida.
6. _____He descubierto un significado de mi vida satisfactorio.
7. _____Estoy siempre buscando algo que haga que mi vida tenga sentido.
8. _____Estoy buscando un objetivo o misión en la vida.
9. _____Mi vida no tiene un propósito claro.
10. _____Estoy buscando el sentido de mi vida.

APPENDIX J

MEANING IN LIFE QUESTIONNAIRE (ENGLISH VERSION)

MLQ. Please take a moment to think about what makes your life feel important to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Please answer according to the scale below:

Completely False	Mostly False	Somewhat False	Neither true nor false.	Somewhat True	Mostly True	Completely True
1	2	3	4	5	6	7

1._____I understand my life's meaning.

2._____I am looking for something that makes my life feel meaningful.

3._____I am always looking to find my life's purpose.

4._____My life has a clear sense of purpose.

5._____I have a good sense of what makes my life meaningful.

6._____I have discovered a satisfying life purpose.

7._____I am always searching for something that makes my life feel significant.

8._____I am seeking a purpose or mission for my life.

9._____My life has no clear purpose.

10._____I am searching for meaning in my life.

MLQ scoring: Presence = 1, 4, 5, 6, & 9-reverse-coded Search = 2, 3, 7, 8, & 10

APPENDIX K:

EXPERIENCES IN CLOSE RELATIONSHIPS-REVISED (SPANISH VERSION)

Cuestionario de Relaciones Interpersonales (ECR-S)

Las siguientes frases se refieren a cómo se siente usted en las relaciones de pareja. Nos interesa cómo vive usted las relaciones de pareja en general, no cómo se está sintiendo en una actual relación. Responda a cada frase indicando en qué grado está de acuerdo o en desacuerdo con cada una de ellas rodeando cada número escogido entre los que encontrará debajo de cada frase.

Totalmente en desacuerdo	**Bastante en desacuerdo**	**Un poco en desacuerdo**	**Ni desacuerdo /ni acuerdo**	**Un poco de acuerdo**	**Bastante de acuerdo**	**Totalmente de acuerdo**
1	**2**	**3**	**4**	**5**	**6**	**7**

1. Prefiero no mostrar a mi pareja cómo me siento por dentro.

1	2	3	4	5	6	7

2. Me preocupa que me abandonen.

1	2	3	4	5	6	7

3. Me siento muy cómodo/a teniendo un alto grado de intimidad con mi pareja.

1	2	3	4	5	6	7

4. Me preocupo mucho por mis relaciones.

1	2	3	4	5	6	7

5. Cuando mi pareja comienza a establecer mayor intimidad conmigo, me doy cuenta que me suelo cerrar.

1	2	3	4	5	6	7

6. Me preocupa que mi pareja no se interese por mí tanto como me intereso yo por ella.

1	2	3	4	5	6	7

7. Me siento violento/a cuando mi pareja quiere demasiada intimidad afectiva.

1	2	3	4	5	6	7

8. Me preocupa bastante el hecho de perder a mi pareja.

1	2	3	4	5	6	7

9. No me siento cómodo/a abriéndome a mi pareja.

1	2	3	4	5	6	7

10. A menudo deseo que los sentimientos de mi pareja hacia mí fueran tan fuertes como mis sentimientos hacia él/ella.

1	2	3	4	5	6	7

11. Quiero acercarme afectivamente a mi pareja, pero a la vez marco las distancias con él/ella.

1	2	3	4	5	6	7

12. A menudo quiero fusionarme completamente con mi pareja, pero me doy cuenta que esto a veces le asusta.

1	2	3	4	5	6	7

13. Me pongo nervioso/a cuando mi pareja consigue demasiada intimidad afectiva conmigo.

1	2	3	4	5	6	7

14. Me preocupa estar sólo/a.

1	2	3	4	5	6	7

15. Me siento a gusto compartiendo mis sentimientos y pensamientos íntimos con mi pareja.

1	2	3	4	5	6	7

16. A veces mi deseo de excesiva intimidad asusta a la gente.

1	2	3	4	5	6	7

17. Intento evitar establecer un grado de intimidad muy elevado con mi pareja.

1	2	3	4	5	6	7

18. Necesito que mi pareja me confirme constantemente que me ama.

1	2	3	4	5	6	7

19. Encuentro relativamente fácil establecer intimidad afectiva con mi pareja.

1	2	3	4	5	6	7

20. A veces siento que presiono a mi pareja para que muestre más sentimientos, más compromiso.

1	2	3	4	5	6	7

21. Encuentro difícil permitirme depender de mi pareja.

1	2	3	4	5	6	7

22. No me preocupa a menudo la idea de ser abandonado/a.

1	2	3	4	5	6	7

23. Prefiero no tener demasiada intimidad afectiva con mi pareja.

1	2	3	4	5	6	7

24. Si no puedo hacer que mi pareja muestre interés por mí, me disgusto o me enfado.

1	2	3	4	5	6	7

25. Se lo cuento todo a mi pareja.

1	2	3	4	5	6	7

26. Creo que mi pareja no quiere tener tanta intimidad afectiva conmigo como a mí me gustaría.

1	2	3	4	5	6	7

27. Normalmente discuto mis problemas y preocupaciones con mi pareja.

1	2	3	4	5	6	7

28. Cuando no tengo una relación, me siento un poco ansioso/a e inseguro/a.

1	2	3	4	5	6	7

29. Me siento bien dependiendo de mi pareja.

1	2	3	4	5	6	7

30. Me siento frustrado/a cuando mi pareja no me hace tanto caso como a mí me gustaría.

1	2	3	4	5	6	7

31. No me importa pedirle a mi pareja consuelo, consejo, o ayuda.

1	2	3	4	5	6	7

32. Me siento frustrado/a si mi pareja no está disponible cuando la necesito.

1	2	3	4	5	6	7

33. Ayuda mucho recurrir a la pareja en épocas de crisis.

1	2	3	4	5	6	7

34. Cuando mi pareja me critica, me siento muy mal.

1	2	3	4	5	6	7

35. Recurro a mi pareja para muchas cosas, entre otras, consuelo y tranquilidad.

1	2	3	4	5	6	7

36. Me tomo a mal que mi pareja pase tiempo lejos de mí.

1	2	3	4	5	6	7

APPENDIX L:

EXPERIENCES IN CLOSE RELATIONSHIPS-REVISED (ENGLISH VERSION)

Experiences in Close Relationships--Revised

The following statements reference how you feel in interpersonal relationships. What is of interest is how you conduct your romantic relationships in general, not how you are feeling about a particular relationship. Respond to each statement indicating the level of agreement or disagreement with each of the statements by circling the appropriate number from those found below each statement.

Strongly Disagree	**Mostly Disagree**	**Somewhat Disagree**	**Neither disagree nor agree**	**Somewhat Agree**	**Mostly Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**	**6**	**7**

1. I prefer not to show a partner how I feel deep down.

1	2	3	4	5	6	7

2. I worry about being abandoned.

1	2	3	4	5	6	7

3. I am very comfortable being close to romantic partners.

1	2	3	4	5	6	7

4. I worry a lot about my relationships.

1	2	3	4	5	6	7

5. Just when my partner starts to get close to me I find myself pulling away.

1	2	3	4	5	6	7

6. I worry that romantic partners wont care about me as much as I care about them.

1	2	3	4	5	6	7

7. I get uncomfortable when a romantic partner wants to be very close.

1	2	3	4	5	6	7

8. I worry a fair amount about losing my partner.

1	2	3	4	5	6	7

9. I don't feel comfortable opening up to romantic partners.

1	2	3	4	5	6	7

10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.

1	2	3	4	5	6	7

11. I want to get close to my partner, but I keep pulling back.

1	2	3	4	5	6	7

12. I often want to merge completely with romantic partners, and this sometimes scares them away.

1	2	3	4	5	6	7

13. I am nervous when partners get too close to me.

1	2	3	4	5	6	7

14. I worry about being alone.

1	2	3	4	5	6	7

15. I feel comfortable sharing my private thoughts and feelings with my partner.

1	2	3	4	5	6	7

16. My desire to be very close sometimes scares people away.

1	2	3	4	5	6	7

17. I try to avoid getting too close to my partner.

1	2	3	4	5	6	7

18. I need a lot of reassurance that I am loved by my partner.

1	2	3	4	5	6	7

19. I find it relatively easy to get close to my partner.

1	2	3	4	5	6	7

20. Sometimes I feel that I force my partners to show more feeling, more commitment.

1	2	3	4	5	6	7

21. I find it difficult to allow myself to depend on romantic partners.

1	2	3	4	5	6	7

22. I do not often worry about being abandoned.

1	2	3	4	5	6	7

23. I prefer not to be too close to romantic partners.

1	2	3	4	5	6	7

24. If I can't get my partner to show interest in me, I get upset or angry.

1	2	3	4	5	6	7

25. I tell my partner just about everything.

1	2	3	4	5	6	7

26. I find that my partner(s) don't want to get as close as I would like.

1	2	3	4	5	6	7

27. I usually discuss my problems and concerns with my partner.

1	2	3	4	5	6	7

28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.

1	2	3	4	5	6	7

29. I feel comfortable depending on romantic partners.

1	2	3	4	5	6	7

30. I get frustrated when my partner is not around as much as I would like.

1	2	3	4	5	6	7

31. I don't mind asking romantic partners for comfort, advice, or help.

1	2	3	4	5	6	7

32. I get frustrated if romantic partners are not available when I need them.

1	2	3	4	5	6	7

33. It helps to turn to my romantic partner in times of need.

1	2	3	4	5	6	7

34. When romantic partners disapprove of me, I feel really bad about myself.

1	2	3	4	5	6	7

35. I turn to my partner for many things, including comfort and reassurance.

1	2	3	4	5	6	7

36. I resent it when my partner spends time away from me.

1	2	3	4	5	6	7

APPENDIX M:

CHILD PTSD SYMPTOM SCALE-REVISED (ENGLISH)

The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

_____

Length of time since the event:

_____

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

1.	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2.	0	1	2	3	Having bad dreams or nightmares
3.	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)
4.	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5.	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6.	0	1	2	3	Trying not to think about, talk about, or have feelings about the event
7.	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
8.	0	1	2	3	Not being able to remember an important part of the upsetting event
9.	0	1	2	3	Having much less interest or doing things you used to do
10.	0	1	2	3	Not feeling close to people around you
11.	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)

12.	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

13.	0	1	2	3	Having trouble falling or staying asleep
14.	0	1	2	3	Feeling irritable or having fits of anger
15.	0	1	2	3	Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class)
16.	0	1	2	3	Being overly careful (for example, checking to see who is around you and what is around you)
17.	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

The Child PTSD Symptom Scale (CPSS) – Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

	Yes	**No**	
18.	**Y**	**N**	Doing your prayers
19.	**Y**	**N**	Chores and duties at home
20.	**Y**	**N**	Relationships with friends
21.	**Y**	**N**	Fun and hobby activities
22.	**Y**	**N**	Schoolwork
23.	**Y**	**N**	Relationships with your family
24.	**Y**	**N**	***General happiness with your life***

VITA

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Department of Leadership and Counselor Education

EDUCATION

University of Mississippi, University, MS, 2011-2014
Ph.D. Counselor Education, May 2014 (completed)

Jackson State University, Jackson, MS, 2005-2008
M.S. Community Counseling, May 2008 (completed)

Notre Dame Seminary, New Orleans, LA, 1996-1997, 1999-2002
M. Div. (Theology), May 2002 (completed)

Rice University, Houston, TX, 1993-1996
B. A. Mathematics and History, May 1996 (completed)

CERTIFICATION

National Certified Counselor (NBCC, Inc.) (September 2008)

REFEREED PUBLICATION IN PROGRESS

Phipps, R., & Degges-White, S. (in press). A new look at transgenerational trauma transmission: Second generation Hispanic immigrants. *Journal of Multicultural Counseling & Development.*

BOOK CHAPTER

Miller-Roach, K., & Phipps, R. (2013). OCD: Signs of and interventions for college students. In S. Degges-White & C. Borzumato-Gainey (Eds.). *College Counseling: A Developmental Approach.* New York: Springer.

SCHOLARLY PRESENTATIONS GIVEN

January 2013—"Trauma in the Middle School Classroom"—Morgantown Middle School, Natchez-Adams (Mississippi) School District (Professional Development)

November 2012—"Childhood Natural Disaster-Related Trauma: Aftermath of the April 2011 Tornado in Smithville, MS"—Mississippi Counseling Association Conference in Biloxi, MS (Conference Presentation)

September 2012—"Literature-Guided Supervision Instruction"—Association for Creativity in Counseling Conference in Memphis, TN (Conference Presentation)

July 2012—"Trauma-Informed Practice"—University of Mississippi, University, MS (Workshop offered for Counselor Education Program)

February 2011—"Religion as a Psychological Empowerment Resource for Immigrants"—Teacher's College at Columbia University, New York, NY (Winter Roundtable Conference)

October 2010—"Perspectives on Pastoral Counseling and Implications for Community Counseling"—Washington, DC (Howard University, Presented to Master's Level students)

GRADUATE-LEVEL CO-TEACHING EXPERIENCE

University of Mississippi
Spring 2012
COUN 643 Group Procedures

Summer 2012
COUN 690 Counseling Skills
COUN 674 Diagnostic Systems in Counseling

Fall 2012
COUN 693 Practicum in Counseling

Spring 2013
COUN 682 Family Counseling

Summer 2013
COUN 595 Spirituality in Counseling
COUN 674 Diagnostic Systems in Counseling

PROFESSIONAL EXPERIENCE

2013—present	*Christ the King and St. Mary Catholic Churches, Jackson, MS* Serve as Pastor, overseeing administrative, liturgical, and community outreach efforts of parish as well as involvement in offering pastoral counseling to adults and adolescents. Also serve as Canonical Administrator of Sister Thea Bowman Catholic School.
2011—2013	*St. Francis of Assisi Catholic Church, New Albany, MS* Served as Pastor, overseeing administrative, liturgical, and community outreach efforts of parish as well as involvement in offering pastoral counseling to adults and adolescents.
2011—2012	*University of Mississippi Counseling Center, University, MS* Worked as Graduate Assistant, having duties of providing individual and couples therapy to students as well as providing triage services to walk-in students or to students or parents by phone.
2011	*Howard University Counseling Center, Washington, DC* Practicum Experience including 4 hours/week of Completing Intake Assessments, 1 hour/week Seminar in Psychoanalytic Theory, 1 hour/week of Group Supervision, and 2 hours/week of Staffing.
2010-2011	*Howard University, Washington, DC* Worked as Graduate Assistant for Howard University Weight Management Study with duties including preparing participant surveys in SurveyMonkey, performing data analysis in SPSS, coordinating communications with study participants, and organizing workshops, other intervention techniques, and focus groups.

2005--2010	*Christ the King and St. Mary Catholic Churches, Jackson, MS* Served as Pastor, overseeing administrative, liturgical, and community outreach efforts of parish as well as involvement in offering pastoral counseling to adults and adolescents. Also served as Canonical Administrator of Sister Thea Bowman Catholic School.
2009	*Catholic Charities—Solomon Counseling Center, Jackson, MS* Served as mental health counselor, offering individual and couples therapy, with focus on therapy with Hispanic/Latino clients, particularly Spanish speaking clients and families and maintaining client charts using Med Ez software.
2007-2008	*Jackson Police Department (MS) Crisis Intervention Unit,* Served as Intern, primarily performing individual Counseling, Group Therapy, and Case Management with Court-ordered Domestic Violence Offenders as well as representing Crisis Intervention Unit in Municipal Court to process Court-ordered Offenders—in fulfillment of 600 Hours Internship Requirement for Master's program.
2002-2005	*St. Francis of Assisi Catholic Church and St. Catherine's Village, Madison, MS* Served as Assistant Pastor, primarily performing liturgical functions, working with children and youth ministry program, offering pastoral counseling, and visiting the elderly and sick in their homes or in hospital settings.
2000	*St. Luke's Hospital, Houston, TX--Clinical Pastoral Education (C.P.E.) Program* Performed visits to patients in assigned areas of hospital (oncology unit), provided pastoral care to entire hospital, particularly emergency room, during 24-hour on-call periods, and participated in regular clinical supervision.
1999	*Jackson Public Schools, Northwest Middle School, Jackson, MS,* 7^{th} Grade Mathematics (Licensed to teach Mathematics, 7^{th} through 12^{th} grades) *Taught 7^{th} grade Mathematics and Pre-Algebra.*

PROFESSIONAL TRAINING

February 2009	Ideal Spanish Language School—Cuernavaca, Morelo, MEXICO Spanish Language Immersion Program
June 2008	Mexican American Cultural Center—San Antonio, TX Spanish Language Program

SERVICE TO THE PROFESSION

Spring 2013	Program Evaluation Team of University of Mississippi Counselor Education Program—2009 CACREP Standards Self-Evaluation
2012-present	Member of American Counseling Association (ACA)